AN INTEGRATIVE MODEL OF CULTURAL INTELLIGENCE AND EMPATHY FOR INTERCULTURAL COMMUNICATION WITH RECENT IMMIGRANTS IN HEALTHCARE CONTEXTS

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Abstract

In our increasingly interconnected world, intercultural communication has gained paramount significance, particularly in contexts characterized by unprecedented cultural diversity, such as healthcare settings. The influx of newcomers from diverse cultural backgrounds necessitates effective intercultural communication, yet this challenge remains uncharted. Nonverbal behaviours, a key communication component, also remain understudied despite their significant cultural variation and influence on the perception of effective communication. Thus, healthcare professionals face the challenge of navigating intricate cultural norms and communication styles without evidence-based guidelines.. This dissertation seeks to unravel the interplay between cultural intelligence and empathic communication through three papers exploring the communication recipient's perspective, nonverbal behaviours' role, and the communication senders' implications. The findings challenge the previous focus on empathy senders and highlight the role of empathy recipients. Nonverbal cues are recognized as pivotal in communication, and culture plays a significant role in interpreting these cues, influencing how empathy is conveyed across cultural boundaries. The dissertation's significance extends beyond healthcare, offering valuable insights for policymakers, international managers, and individuals engaged in intercultural interactions. Education on culturally specific nonverbal cues can enhance self-awareness and improve the capability to provide empathic services to clients from diverse cultural backgrounds. In conclusion, this dissertation is a substantial stride forward in understanding intercultural communication within healthcare, emphasizing the importance of empathy, cultural intelligence, and nonverbal communication. Recognizing cultural differences in nonverbal cues and fostering cultural competence is crucial for healthcare providers to improve patient experiences and their quality of care.

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Introduction

In today's increasingly interconnected world, intercultural communication has become important, especially in service-provision contexts marked by unprecedented cultural diversity (Maddux et al., 2021). As societies around the globe witness a continuous influx of newcomers from diverse cultural backgrounds, the necessity for effective intercultural communication, particularly in healthcare contexts, becomes ever more apparent (Ahmed & Bates, 2017; Ahmed et al., 2016). Healthcare professionals face the daunting task of navigating intricate cultural norms, expectations, and communication styles to deliver equitable and empathetic care. Moreover, they must do so without evidence-based guidelines because research on addressing intercultural communication challenges in healthcare service provision is sparse.

In particular, the role of nonverbal behaviours in communication, which significantly varies across cultures, remains notably understudied (Bonnachio et al., 2016). This is problematic because individuals from different cultural backgrounds (e.g., high-context cultures) may rely relatively heavily on nonverbal (as opposed to verbal) cues to assess the authenticity and sincerity of empathic communication. Moreover, different cultures may prioritize different nonverbal cues. For these reasons, it is useful to identify how a given culture devotes attention to diverse nonverbal cues conveyed by the healthcare service provider (i.e., their facial expressions, body language, and/or tone of voice) as this may influence whether they feel they are truly being understood and cared for.

It is within this dynamic and evolving landscape that this dissertation, titled "AN INTEGRATIVE MODEL OF CULTURAL INTELLIGENCE AND EMPATHY FOR INTERCULTURAL COMMUNICATION WITH RECENT IMMIGRANTS IN HEALTHCARE CONTEXTS," finds its profound significance. This dissertation focuses on how healthcare

providers can effectively communicate with patients from diverse cultural backgrounds. More specifically, the central question driving this research is how to better understand the intricate interplay between cultural intelligence and empathic communication in intercultural healthcare settings. It not only fills gaps in the literatures on intercultural communication, empathy, and cultural intelligence within healthcare contexts but also helps to advance theory in valuable but previously neglected directions. This dissertation is organized into three papers:

Paper 1, a theoretical exploration using a systematized review approach, investigates the significance of perceived empathic communication within intercultural service contexts. Integrating the fragmented coverage across multiple literatures, including the literatures on empathy, cross-cultural communication, and general communication, reveals the limitations of existing scholarship. Notable gaps include an incomplete consideration of nonverbal behaviours, of the recipient's perspective, and of cultural complexity. In the course of its attention to the recipient's perspective within the intercultural communication process, it introduces the novel concept of "intercultural communicated empathy" and constructs a model which elucidates how recipients may appraise attempts at empathic communication.

Paper 2 is an empirical study that attempts to fill the gaps in existing research that were highlighted by the conceptual paper (i.e., the limited emphasis on empathy recipients' perspectives and the neglect of cultural differences in nonverbal cues). It focuses on intercultural communication in healthcare settings from the viewpoint of recipients. Through interviews with thirty participants (Arabic-speaking newcomer patients in Canada), this study explores verbal and nonverbal behaviours perceived as empathic by recipients and examines the cognitive, affective, and behavioural consequences of these perceptions. By amplifying the voices of a minority cultural population, this paper goes beyond gap-filling to advance our understanding of

the role of nonverbal behaviours in intercultural healthcare contexts, which enriches previously incomplete conclusions from the literature. Additionally, it offers practical recommendations for healthcare providers and for the Middle Eastern newcomer community in Canada.

Paper 3 is another empirical study which investigates the intercultural empathic communication process and its implications in healthcare service provision. However, this paper does so by delving into the perspectives of Western/Westernized healthcare *providers* in their interactions with Middle Eastern newcomer patients in Canada. Through semi-structured interviews with twenty-six healthcare providers, this study unveils the complexities inherent in intercultural communication, even among individuals with high cultural intelligence. This research offers novel theoretical insights into the mechanisms guiding empathic communication by healthcare providers. Namely, it sheds light on how empathy – and in particular, healthcare providers' cultural sensitivity to nonverbal attunement - enables even culturally inexperienced practitioners to navigate the intricate tapestry of diverse cultural contexts. It also presents practical recommendations with implications for healthcare and organizational contexts. For example, training programs and interventions can be designed to enhance healthcare professionals' awareness of the role of nonverbal behaviours in conveying empathy.

Taken together, these three studies collectively advance theory in the literatures on empathy and intercultural communication. First, they acknowledge that previous research has predominantly focused on the perspective of empathy senders, often overlooking the experiences and perspectives of empathy recipients. Second, they emphasize the pivotal role of nonverbal behaviours in communication. Namely, they recognize that empathy is not solely about the sender's intentions but also about how the recipients interpret and receive empathic behavioural signals. Nonverbal cues play a critical role in this process. Third, these studies acknowledge the

role of culture in influencing empathy recipients' perspectives on those nonverbal signals. Nonverbal cues convey nuances of emotions and intentions, but they are not used in universal ways. That is, the way that empathy is communicated across cultural boundaries may vary. These are insights that change the degree of confidence we may have in prior research conclusions in this area, which neglected such variables.

The practical importance of the topics explored within this dissertation also cannot be overstated. In today's globalized world, individuals often find themselves in diverse cultural contexts, whether for business, education, or healthcare, without having had any opportunity to acquire in-depth knowledge of the specific cultures they encounter. This dissertation confirms that there is a rich array of nonverbal cues and behaviours that may play a pivotal role in conveying and interpreting emotions and intentions. Accordingly, recognizing and validating the emotions and experiences of others - via nonverbal behavioural communication - effectively creates a humanistic common-ground foundation which serves to bridge cultural gaps. This foundation, in turn, eases collaboration, as it fosters trust between healthcare providers and patients in a way that ultimately enhances patient outcomes.

Although this study focused primarily on the empathic communication experiences and perspectives of Western/ Westernized healthcare providers (in Canada) and their cultural minority patients (Middle Eastern Arabic-speaking newcomers), the findings provide a comprehensive and nuanced understanding of empathy that is nonetheless informative for other intercultural interactions. Specifically, the findings are worthy of consideration not only by other cultural communities and their healthcare providers but also by policymakers and international managers who may seek to enhance intercultural understanding and collaboration in our increasingly globalized world. Intercultural communicators may obtain education on culturally

specific nonverbal cues so as to promote self-awareness of their own nonverbal communication and improve their capability to provide empathic service to clients from diverse cultural backgrounds.

In conclusion, this dissertation represents a substantial stride forward in studying intercultural communication within healthcare contexts, explicitly focusing on empathy and cultural intelligence and their nonverbal enactments. Understanding cultural differences in nonverbal communication and fostering cultural competence are essential for healthcare service providers to connect effectively and care for recipient patients from diverse cultural backgrounds, ultimately enhancing not only the quality of patient experiences but also the quality of healthcare providers' experiences as well.

Empathy through the Lens of Communication Recipients in Intercultural Contexts: A Literature Review and Suggested Model

Abstract

The quality of interactions between senders and their communication recipients is important in our increasingly global, knowledge-based service economy, whether for internally or externally located clients. Whenever an interaction situation that calls for empathy is assessed by recipients as lacking in empathy, unsustainable social and organizational consequences may result. Yet, despite the importance of this, scholarly work on empathic communication suffers from significant weaknesses: It inadequately addresses cultural differences and the role of nonverbal behaviours; the sparse coverage it provides is fragmented across multiple literatures; and it primarily hinges upon the sender's adeptness in discerning the situational nuances of another's and responding appropriately, rather than devoting attention to *how the communication recipient perceives and processes* the sender's empathic expressions and their resultant consequences.

This paper attempts to fill this gap via a systematized review which integrates the cross-cultural communication literature with the empathy and general communication literatures. It offers a novel integrative model derived from the empirical literature of perceived empathy and its consequences, but is currently nonexistent in comprehensive reviews. Additional contributions include a focus on the recipient's perspective and the introduction of the term *intercultural communicated empathy* to denote a culturally diverse communication recipient's appraisal of communication as empathic. The paper concludes by identifying several practical and theoretical implications pertaining to investigating the intercultural empathic communication

between senders and recipients, which further the discourse on intercultural empathic communication and its impact.

Introduction

Service provision in our global knowledge economy relies on effective intercultural interactions (Cikara, Bruneau, & Saxe, 2011; Maddux et al., 2021; Ryan & Wessel, 2015). Yet, senders and recipients from diverse cultures often possess diverse cultural values (e.g., Hofstede, 2001; Trompenaars & Hampden-Turner, 2011), as well as a lack of familiarity with one another (Preston & de Waal, 2002). This creates a lack of common ground – a shared field of reference for communicating (Ronen, 1986; Schramm, 1980), which makes intercultural knowledge-exchange encounters more challenging.

A related cultural challenge arises due to differences in communication styles. This includes not only linguistic differences when speaking the same modern language (e.g., slang, jargon, idioms, proverbs, or euphemisms) (Boers, 2003; Ji et al., 2004; McGlone, 1996; Shehab, Abdul-Rahman & Hussein, 2014) but also myriad other verbal and nonverbal communication style differences. Verbal communication style differences may arise in relation to the appropriate ways to use praise, high versus low context communication, direct versus indirect communication, and use of silence or formality (Jonasson & Lauring, 2012; Raine et al., 2010; Sanchez-Burks et al., 2003; Smith, 2011). Nonverbal communication differences may arise in relation to diverse norms around chronemics, chromatics, display of material possessions, paralanguage, proxemics, haptics, kinesics, facial expression, and/or oculesics (Bonaccio et al., 2016; Ekman et al., 1987; Ekman & Friesen, 1971; Hans & Hans, 2015). The lack of common ground arising from the aforementioned differences in cultural communication styles further

raises the potential for misinterpretations of verbal and nonverbal communication cues between both parties involved in intercultural communication (Cikara et al., 2011).

A growing body of research suggests that *empathic communication* can improve interactional quality with people from different cultural backgrounds (Düringer & Döring, 2012). However, there is a paucity of research regarding the precise empathic behaviours that constitute effective empathic communication in intercultural contexts. In particular, there is a need to better comprehend how recipients process the abundant verbal and nonverbal cues they encounter in attempted empathic intercultural communication (Kellett et al., 2006). This neglect is unfortunate because failing to convey empathy to a recipient effectively would represent a performance failure in intercultural service-provision contexts. There is further uncertainty about whether empathic communication competencies can be cultivated or developed to better accommodate recipients' communication preferences.

It is important to note that this oversight extends beyond the empathy literature. There is a broader deficiency among organizational scholars when exploring the role of nonverbal communication in diverse contexts (Bonaccio et al., 2016). For instance, the field of cross-cultural management has also shown a tendency to overlook the behavioural aspects of conveying empathic communication (Hollan, 2012; Maddux, 2021; Main et al., 2017). In summary, the existing empathy literature inadequately addresses the intricacies of intercultural challenges, while the cross-cultural communication literature appears to provide insufficient attention to empathy. Additionally, both of these bodies of research fail to comprehensively capture the significance of nonverbal behaviours in the context of intercultural empathic communication.

In light of the above objectives, I intend to make three notable contributions. First, I strive to offer a comprehensive and synthesized perspective on the existing empirical literature concerning the firsthand experiences of empathy from its recipients' perspective, drawing from both cross-cultural and communications literatures. My central research question was: How do recipients detect and experience senders' behavioural representations of empathic signals? Why does it matter? Second, I concur with the preliminary findings suggesting that empathy is significant for various social and organizational outcomes. Third, I introduce a deductive model derived from the compilation of empirical research, a model that is notably absent in recent comprehensive reviews (e.g., Clark, Robertson, & Young, 2018).

The remainder of the paper describes my theoretical underpinnings and the methodology I followed. I then present and discuss the synthesis as an evidence-derived model. Finally, I highlight key knowledge gaps and propose future research suggestions.

Theoretical Lens

Shannon and Weaver's (1949) well-established communication model depicts communication interactions as a bi-directional process involving senders and recipients (Main et al., 2017; Zaki, Bolger & Ochsner, 2008). The two-way aspect of this communication process is made evident through a feedback loop involving the recipient's evaluations of the received message. In addition, their model recognizes and incorporates noise sources, such as variations in cultural norms, which helps capture dynamics found in real-life communication interactions.

The Signaling Theory (Connelly et al., 2011) further elaborates on how communication occurs. According to signaling theory, the sender holds insider information important to a specific recipient and then chooses whether or not to deliberately and explicitly convey that

private information. This information asymmetry is a key assumption of the theory (Connelly et al., 2011) and mirrors the reality of intercultural service provider contexts. Based on the communicated message, the recipient can proceed with specific actions that would not have been possible without the information in the communicated message from the sender (i.e., the signal). Specifically, the recipient can choose whether/how to send feedback messages to the sender based on their appraisal of the message (i.e., on what is desired from the senders in future interactions). However, if the sender has failed to convey the information in their possession in a manner understood by the recipient, the recipient may be left unclear about the expected action. In that case, the resultant ambiguity of the sent message may cause the recipient to experience uncertainty about how to respond to the sender (Elitzur & Gavious, 2003; Stiglitz, 2000).

Together, these two theories emphasize that communication exchanges need to be understood from the perspective of all participants, not just from the sender's perspective. Together, they offer a more robust theoretical lens for analyzing empathic intercultural communications.

Methodology

Review Method

A systematic literature review (Tranfield, Denyer, & Smart, 2003) can exhaustively examine a chosen literature (e.g., using many databases). It is a comprehensive and structured approach to reviewing and summarizing existing research on a specific topic or research question. However, it was not feasible due to time and financial resource constraints. This limitation becomes even more pronounced when a single researcher handles the entire review process.

An alternative but still satisfactory approach is a systematized review of the literature. Less exhaustive than systematic reviews, systematized reviews can still enable the investigation of new and multidisciplinary topics via a comprehensive search of purposefully selected/ relevant databases (Grant & Booth, 2009). Although this approach involves fewer databases, it nonetheless allows for a rich descriptive analysis of the literature collected, subsequent consolidation/synthesis of the findings, and identification of the knowledge gaps and key limitations in the literature.

Thus, a systematized approach was adopted to the literature on communicated empathy (Crossan & Apaydin, 2010). This approach enabled me to structure and integrate the research findings on the signaling theory of communication (Connelly et al., 2011) and the communication model (Shannon & Weaver, 1949), ultimately offering valuable insights contributing to understanding the research.

Procedure

Choice of Database and Language

I searched five online scientific databases to identify potential studies (Web of Science, Scopus, ProQuest One Business, Business Source Complete and APA PsychInfo ProQuest). I chose these five databases because of their comprehensiveness and interdisciplinary nature, which offer a thorough overview of peer-reviewed literature across disciplines. The literature search, completed in October 2021, was also restricted to peer-reviewed publications in English.

Keywords for the Search

Initially, I used the search term "empath*." However, given the diverse ways in which this term is used, the search results initially yielded an excessive number of articles, over 30,000 publications, including in the medical context and in the fields of Psychiatry and Psychotherapy,

where empathy is part of the medical/clinical regimen, that did not necessarily serve the aim of this review. In addition, many studies did not investigate empathy as their focal construct. Hence, I sought to refine the article results pool using several terms and combinations of keywords that I deemed appropriate for this review. Specifically, I searched the databases using terms such as "perceived empathy" and "judged empathy", as well as the words "empathy and service provider" within a five-word distance. I also used the "*" wildcard to include variations of the used terms. Table 1 demonstrates the complete list of keywords I used in the databases' searches, the databases covered and the results from each database.

INSERT TABLE 1 HERE

Study Type and Date Range

As the next filter, I focused on including studies on empathy that were (a) empirical and (b) were published during the years of 2015-2021. This cut-off was determined to be an appropriate range of years based on the statistics provided by Scopus and Web of Science databases. Namely, both databases demonstrated similar publication trends per year and the number of citations per year on empathy: Publications on this topic started in the 1980s and grew exponentially in the 2010s (Konrath, O'Brien & Hsing, 2011). In addition, after 2015, there was notable additional growth in attention to it. I searched the results using the terms "method," "empirical," "evidence," and "measure" to identify empirical studies.

After applying the primary inclusion/exclusion criteria, 2,694 studies were retrieved. Inspired by Mazutis & Zintel's (2015) procedure of narrative reviews, I manually examined the reference lists of three critical reviews identified on empathy (Clark, Robertson & Young, 2019;

Cuff et al., 2016; Main et al., 2017). The reviews I deemed critical were widely cited and published in leading reputable journals. However, the examination did not yield any additional empirical evidence. Hence, reviewing the reference lists of the other 16 included studies was deemed redundant and unnecessary.

Additional Contextually Relevant Criteria

After removing duplicates, I then applied four additional criteria (see Figure 1 for the PRISMA diagram): Namely, I sought studies on empathy that were (a) interpersonal (i.e., involved more than one person and experiences were distinguished and/or shared, as per Main et al., 2017), (b) considered the recipient's perspective, (c) addressed service-provider work contexts, whether they were internal clients or external ones; and (d) focused on observable empathic behaviours in the empathic communication process but were not overly narrow in doing so (i.e., as in clinical empathy in Psychiatry, where empathy was the main outcome of interest, contrary to other health care or other service-provider work contexts, where empathic communication represented more a means of attaining the desired outcomes).

INSERT FIGURE 1 HERE

Data Available for Synthesis

The thesis advisor and I reviewed the abstracts of the remaining studies closely to ensure they fully conformed with the four inclusion criteria. This abstract review resulted in ninety-three studies, which we then subjected to a full-paper review based on the same criteria. Following the full-paper review, sixteen studies were ultimately found to address all the criteria and were included in the synthesis.

The resultant low number of articles (16) indicates the lack of attention devoted by many reputable peer-reviewed journals to the recipients' perspective (i.e., to the interpersonal nature of empathy). Nevertheless, I noted that this final sample size of articles is fully compatible with a recent leading literature review on a related construct, compassion (Sinclair et al., 2016): Only one-third of the forty-four studies in that review investigated the recipients' side. In addition, this search was broader (i.e., spanned more diverse literatures) and more suitable (i.e., focused on the contextually relevant criteria noted above) than the databases used in previous recent literature reviews on empathy (Clark et al., 2019; Cuff et al., 2016).

All the relevant details of the remaining studies were entered into Excel and summarized in Table 2 below. I indicated the type of participants sampled in this review to highlight whether the settings included intercultural contexts. As the table indicates, these studies included a variety of population contexts on the receiving side of empathy, including both public sector organizations (e.g., patients in culturally diverse healthcare settings, university students) and private sector organizations (e.g., employees and their external clients).

INSERT TABLE 2 HERE

Including studies with this broad diversity of client populations was intentional because investigations of empathy are still in their early stages and remain fragmented. Consequently, there was a need for a comprehensive review of the extensive literature to pinpoint areas where additional research, both in terms of interpersonal and intercultural aspects, can bring valuable insights. This broad set of populations also allowed for identifying abundant research opportunities to understand further and develop the construct of communicated empathy.

Therefore, carefully combining diverse literature offers the potential to theoretically inform the cross-cultural and general communication literatures and provide practical insights relevant to various organizational contexts where empathic intercultural service provision is essential.

Results

The results section begins with observations about the methodological limitations in the empathy literature. In this initial results section, I demonstrate how studies have primarily adopted a non-behavioural, non-interactive approach to defining the communication of empathy in interpersonal contexts. Next, I delve into how empathy has been defined, including whether it has been depicted as malleable or not, and I review the three aspects of empathy (cognitive, affective, and behavioural), including how they have been operationalized and the limitations of those operationalizations. In the third findings section, I present and elaborate on the deductive model resulting from reviewing the compiled studies. For example, I review the consequences that have been noted to result from the successful communication of empathy and address their limitations (e.g., failing to consider which aspect of empathy was communicated). Finally, I review potentially important influences on the empathic communication context that the literature appears to have neglected (e.g., expectations surrounding the specific service-provision context and/or how the recipient's culture may influence the interpretation of these behavioural empathic cues).

In summary, the outcomes of this review underscore that communicated empathy is potentially underrepresented in empirical research. Even when researchers delve into this area, they often fail to capture the recipients' perspectives comprehensively.

Methodological Limitations in Empathy Research

Empirical findings, including comprehensive literature reviews on empathy (e.g., Clark et al., 2019; Cuff et al., 2016), suggest that studies have largely relied on self-report measures and have studied primarily the perspective of the sender with only a rare exploration of the view of the recipient (Konrath et al., 2011; Malik et al., 2014; Wondra & Ellsworth, 2015; Zaki, 2014). For example, in Daniels et al.'s (2014) study on call center administrators, the researchers stated that "Empathy occurs when another recognizes the expressor's affective state and identifies with the expressor's perspective on the reasons for that affective state." (p. 787). Likewise, Meinecke and Kauffeld's (2019) view of empathy in the context of leadership was limited to "a leader's ability to accurately recognize and understand the emotional reactions and feelings of their followers." (p. 3). Indeed, even in healthcare contexts, it seemed sufficient to know that the provider sees themselves as empathic but not to consider the patient recipient's perspective simultaneously. It seems that not enough researchers ask the *recipients* whether or how they felt empathy (or lack thereof) (e.g. If they felt it, why did they feel understood? How were their emotions recognized and respected? Were their behaviours mirrored in ways that made them feel integrated, understood, comforted, or simply mimicked?). Clark et al. (2019) were one of the few studies that briefly acknowledged the recipients' perspective by referencing a construct that they termed 'judged empathy.' However, their study involved no data collection on recipients' experiences.

Thus, as Table 2 shows, the empirical literature on empathy has inadequately considered the possibility of difference between the sender's and recipient's perspectives. This omission, which effectively undermines the views and experiences of the recipients of empathy, has occurred despite preliminary recognition that the recipients' experience of empathy is important

and that it may significantly differ from the senders' views (Barkham & Shapiro, 1986; Main et al., 2017).

Definition of Empathy: A Fixed Ability or Malleable Competency?

Cuff et al. (2016) conducted an extensive review that revealed 43 different definitions of empathy from the existing literature. It is also worth noting that there has been variability in the evidence concerning whether this empathic competency represents an inherent and unchanging trait or a flexible attribute that can be developed, encompassing knowledge, attitude, or skill.

Scholars who have depicted empathy as a fixed ability describe an empathizer as someone who is "psychologically in tune with others' feelings and perspectives" (Chopik et al., 2017, p. 23) and who responds "compassionately to another person's needs, motivations, or opinions by communicating their understanding." (Meinecke & Kauffeld, 2019, p. 486). This way of relating to others "promotes cooperation and unity rather than conflict and isolation" (Konrath et al., 2011, p. 180).

Others have considered empathy in more malleable terms. For example, Cikara et al. (2011) found that people typically develop more empathy with members of their social ingroup than outgroup members, suggesting that empathy can be cultivated via socialization. Indeed, the capacity for people to become more empathic with familiar creatures of all kinds is evidenced by the fact that they report more empathy with their dog than with an unknown beggar on the street (Preston & De Waal 2002).

Thus, based on the analyzed studies, this review suggests that at least certain empathy aspects may be malleable (Batson, 2009). Hence, for this review, I concur with Clarke et al.'s (2019) definition of empathy as a 'multidimensional construct operating at *both* trait and state levels' (p.167, italics added).

Importantly, for the purposes of this review, it is also noteworthy that empirical research on the malleable aspects of empathy has largely been confined to research on attitudes. Although two recent qualitative reviews on empathy (Clark et al., 2019; Cuff et al., 2016) have acknowledged that empathy may be defined in terms of behavioural skills, these studies lacked detailed and empirical data. Nevertheless, there is a consensus among researchers that empathy is a competency that *should* be actively cultivated (Clark et al., 2019).

The Resultant Model

For the above reasons, this section draws upon the integrative review across diverse literatures to develop a model which illustrates a more detailed understanding of these malleable definitions of empathy, addressing how attitudinal aspects (cognitive and affective) may manifest in behavioural form (e.g., not only in the verbal and nonverbal expressions that may enable empathy to be detected by recipients but even at the physiological level of the brain). The deductive compilation model is illustrated in Figure 2. This model depicts communicated behavioural empathy, including verbal and nonverbal behaviours perceived as empathic by recipients, in the left box of Figure 2. It also encompasses the experience of empathy resulting from communicated cognitive and affective empathy, positioned in the middle box of Figure 2. Additionally, I categorized the outcomes explored in the literature into cognitive, affective, and behavioural dimensions, which are situated on the right side of Figure 2. Furthermore, I have identified several key moderators influencing how recipients evaluate empathic communication. Each of these aspects is discussed in the following sections.

INSERT FIGURE 2 HERE

The Experience of Communicated Empathy

Cognitive Empathy. Cognitive empathy refers to an individual's capacity to *cognitively* understand another's internal thoughts and feelings (Clark et al., 2019). For instance, Davis (1983) described cognitive empathy as a process of perspective-taking, namely, cognitively imagining oneself in the other person's position to better grasp the other communicating party's thoughts and feelings.

In terms of the measurement of cognitive empathy, a number of studies have attempted to use neuroimaging (Clark et al., 2019). For example, Shamay-Tsoory (2011) demonstrated that specific brain regions form the cognitive empathy network that enables senders who have seen another individual's pain to comprehend that person's perspective. Another higher-level approach to measurement, used by Besel and Yuille (2010), employed a self-report scale. They conjectured that perspective-taking might require, at the very least, the capacity to detect nonverbal behaviours (i.e., body language). They investigated this by replicating Ekman's famous experiments (e.g., Ekman et al., 1987) on the six universal nonverbal facial expressions of emotions and by capturing individual differences in cognitive interpretations. Yet, they found that their measurement of the sender's self-reported cognitive empathy was not associated with accurately recognizing static emotional facial expressions. While this study did not detect a significant correlation between self-reported cognitive empathy and the accuracy of facial affect recognition, this may be because it employed static images rather than a live actor. Nevertheless, it helpfully flagged the potentially important role of nonverbal behaviours in forming cognitive empathy within an interpersonal communication context.

Yet, the analyzed empirical studies have failed to adopt a thoroughly interpersonal approach, as they focused mainly on processes within the sender (who is deemed to possess cognitive empathy) rather than on validation by a recipient (i.e., the individual negotiating

cognitive empathy). As a result, these studies also neglected to explain the interpersonal process by which senders develop and then convey this empathic cognitive understanding in a manner that the recipient may detect. Thus, this review asserts that *the recipient* should be the ultimate adjudicator of whether the sender has cognitively grasped the recipient's perspective (internal thoughts and affective states). Accordingly, "communicated cognitive empathy" is defined as the recipient's experience that the sender's verbal and nonverbal messages convey that they have adequately detected the recipient's perspective.

Affective Empathy. Affective empathy is believed to be the earliest aspect of empathy that people experience (Clark et al., 2019; Sagi and Hoffman, 1976). As Clark et al. (2019) emphasized, the construct of affective empathy implies emotional congruency (i.e., a willful sharing of the recipient's feelings, reflecting unconditional regard as per Bonaccio et al., 2016; Carroll et al., 2007; and Silvester et al., 2007).

Emotional congruency differentiates empathy from the constructs of sympathy and compassion (Clark et al., 2019). The emotional congruency aspect of empathy involves deeply understanding and closely sharing in the emotions and thoughts of another (i.e., feeling with). By contrast, sympathy is a more distal, passive acknowledgment of those emotions (i.e., feeling for). In contrast, compassion is a more action-oriented desire (i.e., involving an intention to alleviate the suffering of others through proactive and empathic actions) (Zaki, 2014). These nuanced distinctions are important in understanding the motivation and range of responses individuals may *exhibit* in response to others' thoughts and emotions (as well as the range of responses individuals may *look for* when experiencing their own difficult emotions).

Hence, "communicated affective empathy" is defined here as the recipient's emotional experience in that the sender has willingly shared the recipient's affective experience in a

congruent manner during the interaction. Emotional congruence could potentially be measured in the communication process by documenting visible cues detected by the recipient during their communication experience – i.e. the nonverbal and verbal signals that represent, for them, indicators of empathy during the interaction. This approach to measuring affective empathy aligns with the theoretical lens for this review, which emphasizes signalled cues and the recipient's capacity to detect them.

Yet, as with the cognitive aspect, studies that attempted to measure the affective aspects of empathy were initially based on neurological research that examined which areas of the brain are activated when witnessing an affective experience of another (Bernhardt & Singer, 2012; Riess & Neporent, 2018). Many of these neuro-studies revealed that the experience of affective empathy toward another person activated the same parts of the sender's brain that were activated in the recipient's brain, the latter of whom was experiencing the affective state firsthand. While interesting, these neuro measurements did not help to inform the interpersonal dynamics within the communication process, as the firing of the sender's neurons is hidden from the recipient.

Behavioural Indicators of Communicated Empathy

There has been some debate about whether behavioural empathy represents a third independent aspect of empathy or merely an expression of the sender's cognitive and affective empathy (Cikara et al., 2011; Clark, 2010; Cuff et al., 2016). I adopted the latter understanding for this paper for several reasons. First, cognitive-behavioural theory (Beck, 1964) has shown that thoughts and feelings significantly influence behaviour. Second, mental health research suggests it is challenging for healthy adults to exhibit behavioural empathy without the cognitive and affective components that underpin and drive it. The only documented exceptions in the empathy literature typically involve outliers, such as psychopaths or individuals with autism

(Blair, 2008). In such cases, these individuals may intentionally enact behaviours that do not align with their authentic emotional experiences or have limited capacity to experience empathy.

Given that this review is based on literature that has not addressed senders who are autistic or psychopathic, it is, therefore, reasonable to regard the behavioural component of empathy as dependent. Accordingly, the "communicated behavioural aspect of empathy" is defined as the recipient's experience that the sender displays a combination of verbal and nonverbal behaviours that convey both communicated cognitive and communicated affective empathy. The section below elaborates on the specific verbal and nonverbal behavioural cues that may convey cognitive and affective empathy, which are also summarized in column #7 of Table 2.

Verbal Empathy Cues. The literature reflected a range of verbal communication activities senders engage in that are considered signalling cues of empathy by the recipients (Barkham & Shapiro, 1986). These verbal responses may be classified according to three categories:

The first category reflects what was termed "relationship-oriented (humanistic) queries," which reflects an approach that empowers the recipient by effectively acknowledging their initial need to be heard and understood as a person rather than immediately asked to respond to some task-related question by a presumed (or actual) expert. Humanistic queries involve the sender initiating open-ended questions that allow the recipient space for emotional expression (Raine et al., 2010; Sanders et al., 2021; Sternke et al., 2016). Although not specified in previous research, this active listening approach may be understood to represent the effective enactment of cognitive empathy because it can help establish common grounding in the sender and recipient's respective "frames of reference" (Barkham & Shapiro, 1986, p. 8; Ronen, 1986; Schramm,

1980), prior to delving straight into the main issue at hand (i.e., engaging in the service provision).

The second category involves the use of verbal, active listening behaviours and responses, alternately described as "paraphrasing" in the literature (Hafskjold et al., 2017; Lord et al., 2015; Meinecke & Kauffeld, 2019; Packard et al., 2018; Packard & Burnham, 2021; Seehausen et al., 2012, 2016). Although not specified in previous research, this indicator may be understood to represent the effective enactment of both cognitive and affective empathy, as it involves the sender verbally demonstrating that they understand the recipient's thoughts and feelings during interpersonal and intercultural interactions by paraphrasing or restating the exact words in a different form (i.e., demonstrating perspective taking). These helpful behaviours may also convey that the sender cares about accurately sharing the recipient's state, provides the impression that the recipient is being heard and understood (Seehausen et al., 2016), and represents a verbal indicator of patience (Carroll et al., 2007), which may be considered indicative of affective empathy.

A third category of verbal cues is the "provision of empowering, informative, and reassuring words" to recipients. Although not explicitly categorized as such in the reviewed empirical studies, this indicator may be understood to represent the effective enactment of affective empathy. That is, verbally involving the recipient in the decision-making process and arguably expressing a willingness to share in the recipient's affective need to make independent choices, which, in turn, represents an empowering cue (Ahmed et al., 2016; Derksen et al., 2017; Mercer et al., 2016; Sanders et al., 2021; Silvester et al., 2007; Tan, Muskat & Johns, 2019).

Nonverbal Empathy Cues. Much less research attention has been devoted to the nonverbal communication cues that can behaviourally convey empathy in organizational

contexts (Bonaccio et al., 2016). Nevertheless, some researchers (e.g., Yeheskel & Rawal, 2019) have addressed the potential utility of nonverbal communication. This review found that there were three key categories of nonverbal cues relevant to empathic communication:

First, physical attire is an aspect of appearance and represents one form of nonverbal communication (Bonaccio et al., 2016; Chung et al., 2012; Küster & Swiderska, 2021; Matsuhisa et al., 2021) that is often symbolic of specific occupations. Appropriate attire can thus potentially indicate consideration for recipients' subjective notions of service-provider norms. As role congruity theory (Eagly & Karau, 2002) posits, senders who exhibit all the necessary role behaviours expected by recipients will leave recipients feeling more confident in the senders' capability to perform their role.

Second, posture represents a form of kinesics (Bonaccio et al., 2016) that may be important for conveying empathy. More specifically, immediacy is the term coined to encompass a spectrum of kinesic behaviours that convey liking and approach, such as genuine smiling and leaning toward another (Mehrabian & Ferris, 1967; Bonaccio et al., 2016). Indeed, this bodily orientation (immediacy) may influence the evaluation of empathy. In one interesting study on student dyads, senders changed their posture to sit in either a mirroring or a non-mirroring posture during an eight-minute meeting. Recipients (in this study, students) in mirroring situations rated their senders as more empathic (more understanding and capable of building rapport) than those who did not imitate their recipients (Fujiwara & Daibo, 2021). Similar results were found concerning body leaning (Dowell & Berman, 2013; Kraft-Todd et al., 2017). As opposed to upright or backward postures, forward body lean reflected immediacy and empathy, as depicted by the recipients.

A third nonverbal behaviour that emerged from empirical studies as relevant to evaluations of empathy is eye contact (Kraft-Todd et al., 2017). In an experimental setting, senders with direct eye contact were judged as more empathic (likely because of immediacy) than senders with less direct eye contact. Interestingly, an earlier study examined the interaction between eye contact and posture (body leaning). The researchers demonstrated that when both direct eye contact and forward posture existed, the experience of empathy was significantly higher than when only one of these enactments of nonverbal behaviour was present (Dowell & Berman, 2013).

As informative as these findings are, these studies often describe how such cues contribute to the experience of empathy without clarifying *which* aspect of communicated empathy was experienced and providing sufficient descriptions of the contexts where communication happened. Nevertheless, based on the trajectory of the findings, it seems that physical attire may trigger recipients' experience of cognitive empathy. In contrast, kinesics and eye contact cues may trigger the recipient's experiences of affective empathy.

Equally important, the empirical studies reviewed incompletely address how the experience of empathy may impact social and organizational consequences. In addition, they neglect to elaborate on how aspects of the context (e.g., the nature of the empathic communication required and/or the presence of cultural diversity in the interaction) may influence those consequences. Therefore, The next findings section delves into the potential consequences of communicated empathy. Subsequently, I elaborate on the potential contextual influences on those consequences, as synthesized from the literature.

Consequences of Communicated Empathy

Cognitive Outcomes. ***Confidence in Sender.*** Empirical evidence demonstrates that recipients of empathy are inclined to develop a perception of the sender's trustworthiness and competency, reflecting an overall confidence in the sender (Chung et al., 2012). This response enhances their openness to accept the sender's requests (Derksen et al., 2017). Recipients' experiences of empathy were also directly related to their perceptions of the sender's authenticity of leadership (Kellett et al., 2002; Meinecke & Kauffeld, 2019).

Affective Outcomes. ***Positive Affect (Self-regulation).*** Evidence suggests that the recipient's experience of communicated empathy is related to the recipient's well-being (i.e., positive and negative affect). For example, neurotechnology studies investigated how verbal cues (using cognitive and affective comments) influenced the activation of the emotion-centred areas of the brain. They revealed that empathic verbal cues positively influenced the recipient's affective states and that empathic verbal responses following negative feedback reduced negative affect (Seehausen et al., 2012, 2016).

One explanation for this finding about affect could pertain to how the recipient's experience of communicated empathy influences their capacity for self-regulation. For example, in a healthcare setting, patients rated their physicians as more empathic when the physicians provided sufficient information about the diagnosis and the treatment (provision of information) and positive and supportive comments (provision of assurance) (Silvester et al., 2007). Recipients who report empathy are inclined to develop a sense of safety with the sender (Chung et al., 2012). In turn, these evaluations led not only to the development of effective therapeutic relationships (Hafskjold et al., 2017) but also to effective coping and an increased capacity to tolerate stressful situations (Derksen et al., 2017).

Behavioural Outcomes. **Engagement in Interaction.** As noted in the cognitive outcomes section, demonstrating reassurance and providing information to recipients fosters an environment of trust and tolerance. This, in turn, enables senders and recipients to have open conversations, allowing information and idea exchanges. In an intercultural setting, as Malik et al. (2014) theorized, an environment of trust may enable culturally different individuals to integrate and socialize within an organization context. Such outcomes are also empirically evident in healthcare settings (Derksen et al., 2017; Hafskjold et al., 2017). For example, researchers found that empathic communication styles in an antenatal care unit led to effective patient engagement and accurate answering of physician questions. In addition, in contrast with situations where empathy was not communicated, patients in communicated empathy situations felt a positive, constructive atmosphere with their physicians, which empowered them to ask for (and gain) the care they required (Raine et al., 2010).

Behavioural Outcomes. **Agreeable Compliance.** Empirical evidence from the healthcare service provision context demonstrates that, from a behavioural standpoint, patients who developed great confidence in their physicians were committed to their treatments and successfully attended all their medical appointments (Derksen et al., 2017; Mercer et al., 2016; Sternke et al., 2016). In another study, pregnant women who believed their physicians were more supportive and reassuring exhibited greater patience during their medical visits (Raine et al., 2010). Likewise, students who detected empathy via individualized attention from their mentors in an educational setting became more trusting and inclined to commit further and engage in their learning experience (Tan et al., 2019).

Potential Moderators of the Relationship between Communicated Empathy & and Outcomes

The literature has overlooked several potentially significant moderating influences pertinent to the specific service-provision context. One is the type of service in which the sender and recipient are engaged (which may dictate the nature of the empathic communication needed). Another is the degree of cultural diversity in the empathic service situation, which may also influence the nature of the empathic communication required as well as how empathic communication is depicted.

Nature of the Empathic Requirement in the Interaction Context

Considering what recipients want and anticipate from senders within a specific service-provision context is a pertinent issue highlighted by Bechtoldt et al. (2019). While most of the reviewed studies exploring the outcomes of empathy have primarily focused on healthcare settings, similar observations have emerged in an organizational context involving leaders and followers. For example, Meinecke and Kauffeld (2019) discovered that leaders who utilized verbal paraphrasing, matched their language style with their employees, and did so during performance appraisal interviews were perceived as more empathic and likable by their interviewees. However, it is worth noting that this context was not inherently a service provision context. Indeed, service provision contexts necessitating empathy have received relatively limited attention within the organizational behaviour literature (Bonaccio et al., 2016).

Consequently, it remains unclear whether the same outcomes observed in other contexts will also apply in these service-oriented settings. It is plausible that the role of communicated empathy in regulating recipients' emotions holds significance in any high-stress client service occupation or situations where conveying negative news or feedback is essential. Nevertheless, empirical research is imperative to categorize further and explore these potential dynamics.

Cultural Differences

Most of the reviewed studies on empathy have been conducted in monocultural contexts. Yet, cross-cultural research indicates that cultural preferences dictate how individuals express themselves and negotiate for empathy (Bonaccio et al., 2016; Hollan, 2012). Cultural preferences also influence how individuals react to others' behaviours. Because cultural communication norms and values may influence the experience of communicated empathy (via verbal and nonverbal behavioural cues), consequences associated with the experiences of empathy may also vary. Hence, scholars have called for empathy studies to become "culturally situated" (Main et al., 2017, p. 364).

More specifically, regarding verbal communication, the same words selected can be interpreted differently by recipients when their first language differs from the sender's (Balaji et al., 2017). Contextual differences (e.g., power distance between the interaction partners) may also interact with cultural constraints (e.g., communication norms regarding power distance) to the appropriateness of verbal communication approaches and the consequences arising from those (Eylon & Au, 1999; Hollan, 2012; Jonasson & Lauring, 2012; Main et al., 2017). In addition, low-context cultures may rely more on direct verbal expressions to communicate, whereas high-context cultures may rely more on nonverbal expressions (Jonasson & Lauring, 2012; Raine et al., 2010; Sanchez-Burks et al., 2003; Smith, 2011).

Three issues may be noted to elaborate on the potential consequences of nonverbal communication: First, cultures high in formality (Jonasson & Lauring, 2012; Smith, 2011) and/or power distance (Eylon & Au, 1999) may place significance on the adherence (or relaxation) of formal attire. Hence, a service provider in intercultural contexts may more effectively convey empathy when they demonstrate sensitivity to this.

Second, different cultures may regard immediacy differently due to diverse preferences for social distance/proxemics (Bonaccio et al., 2016; Sanchez-Burks et al., 2003). Because cultural differences may influence whether immediacy behaviours will be interpreted as welcome or intrusive, the recipient's affective empathy experience may also vary (Main et al., 2017). What one culture considers appropriate regarding the level of touch in a particular situation may also differ significantly from another (Carroll et al., 2007). Thus, appropriately delivering and interpreting nonverbal immediacy in *intercultural* contexts may be particularly fraught with challenges (Ahmed et al., 2016; Bonaccio et al., 2016; O'Sullivan, 2017).

In addition, Trompenaars & Hampden-Turner's (2011) affective/neutral cultural value dimension suggests that empathy communicators may need to be mindful of how vigorously emotions are expressed (be it verbally - via the use of dramatic words – and/or non-verbally). For example, highly affective cultures show their emotions with many animated gestures (and expect the same in return) (Main et al., 2017). In contrast, more neutral cultures are more subtle/reserved in their nonverbal expressions.

All of these cultural differences influence contextual expectations, which may, in turn, affect the quality of the interpersonal interaction and the evaluation of communicated empathy. Therefore, in the discussion section, I integrate these considerations and summarize the developed model of "communicated empathy." I then outline theoretical contributions and practical implications that may flow from it.

Discussion

Summary

Empathy Research Has Been Highly Fragmented

While the management literature has applied signaling theory to various managerial actions involving communicated signals (Connelly et al., 2011), the *cross-cultural management* literature has yet to explore the application of this theory to the communication of empathy within intercultural organizational or service provision contexts. Within the cross-cultural literature, the primary focus has been on understanding the impact of cultural differences on communication (Maddux et al., 2021), often overlooking the potential role of empathy in mitigating challenges in intercultural communication. This assumption is significant, especially when high cultural competency and prior knowledge of the culture are lacking. In addition, the *general communication literature* has examined empathic communication but has largely overlooked the potential influence of nonverbal behaviours in fostering successful intercultural empathic communication. Similarly, *the literature on healthcare service provision* has examined intercultural and empathic communication separately (e.g., Ahmed et al., 2016; Silvester et al., 2007) but have not delved into both sides of the communication equation (sender and recipient) simultaneously, nor have they applied the lens of signaling theory. In summary, while some existing literatures recognize the importance of empathy and others recognize nonverbal behavioural cues as vital communication signals, they have not spoken to one another. Consequently, we know little about how and why these cues impact the empathic communication process, both in general and within intercultural contexts. This study has addressed the calls from scholars for a deeper understanding of the behavioural aspects of empathic communication, encompassing its verbal and nonverbal components, with a specific focus on how these components may unfold in intercultural contexts.

Empathy Research Has Taken a Self-Absorbed Perspective

In addition, for a construct grounded in interpersonal communication theory, it seems paradoxical that much of the present literature has not differentiated between enacted empathy and experienced empathy (the latter have been labelled 'communicated empathy' in this review). Little attention has been devoted to the recipient's side. Despite several empirical studies and extensive reviews that have underscored the importance of empathy, researchers have largely overlooked the voices of its recipients (Barkham & Shapiro, 1986). The model developed in this paper addresses the limitation of existing research: It defines empathy as a bi-directional process involving senders and recipients of empathic communications in different social and organizational contexts (Clark et al., 2019; Cuff et al., 2016; Zaki et al., 2008).

Empathy Research Has Neglected Nonverbal Behaviours

Not only have empirical studies typically focused exclusively on the senders' side of empathy, but they have also relied primarily on self-reported measures of how the (sending) person sees themselves as empathic. This review has not only integrated disparate literatures, but doing so has revealed that the processes by which empathy is communicated (i.e., indicators) involve both verbal (Barkham & Shapiro, 1986; Raine et al., 2010; Seehausen et al., 2012, 2016; Silvester et al., 2007) and nonverbal cues (Bonaccio et al., 2016; Chung et al., 2012; Dowell & Berman, 2013; Maurer & Tindall, 1983) and illustrated that these might be understood through the lens of signaling theory.

Empathy Research Has Neglected Intercultural Contexts

As previously noted, little was known about the breadth of behavioural cues pertinent to demonstrating empathy in intercultural contexts. Hence, this paper has underscored why cultural variables are relevant. Specifically, the developed model underscores the myriad ways in which a range of culturally preferred nonverbal behaviours and cultural values may systematically impact

empathy in intercultural social and organizational service-provision contexts and providing rich descriptions.

Empathy Research Has Neglected the Full Spectrum of Outcomes

Overall, there is limited empirical evidence to conclude that attention to the cultural aspects of empathic communication matters for recipients to effectively experience the intended communication of empathy. By integrating disparate literatures in this manner, I was able to more thoroughly examine the range of outcomes of communicated empathy for recipients (Raine et al., 2010; Scott et al., 2010; Seehausen et al., 2012, 2016).

Theoretical Contributions

The above contributions refer to ways in which this paper has filled needed gaps in the literature. However, this paper's contributions go beyond gap-filling because they advance theory in a number of important ways:

First, this paper provides a fresh perspective on empathic communication by systematically examining how its recipients may perceive it. In so doing, this review reveals potential limitations to the validity of earlier research that neglected the recipient perspective. For example, Ho and Gupta's (2012) study in the upscale international hotel industry in Singapore explored the impact of employees' empathic perspective-taking on their citizenship behaviour towards guests. Their findings demonstrated a strong link between empathic perspective-taking and increased positive guest-directed behaviours and, to a limited extent, impact in the form of reduced negative behaviours as well. That is when employees genuinely empathized with their guests by understanding their needs and emotions, they tended to display more favourable actions. However, it is worth noting that the study relied on self-reports from employees. If it had included guest perspectives, it could have yielded different conclusions.

Guest perceptions of employee empathy could have more validly determined whether these employee behaviours genuinely enhanced the guest experience. This would have provided insights into whether different guests appreciated these actions or preferred alternative services. Thus, this paper’s introduction of the construct of “communicated empathy" advances theory not only by conceptualizing its various facets but also by better representing the impact for recipients.

Second, this paper highlights the neglected issue of how cultural differences between sender and recipient may influence the recipient’s experience of empathic interpersonal interactions. Attention to this cultural issue fills a critical gap that has been neglected by other, more recent literature reviews on empathic communication (e.g., Clark et al., 2019; Cuff et al., 2016). However, this contribution, too, goes beyond gap-filling – it, too, raises important questions about the validity of conclusions in previous research. For example, Ho and Gupta's (2012) study could have gained deeper insights by considering cultural value dimensions, such as Trompenaars and Hampden-Turner's (2012) cultural dimension of affective versus neutral, which may influence how people perceive, enact and respond to empathy in the hospitality industry. In other words, different client cultures may have varying expectations for visible affect in employee behaviour: Some cultures may expect high levels of attentiveness and empathy, while others may prefer a more reserved approach. Furthermore, culture also shapes communication styles, influencing how guests interpret employee perspective-taking: Some cultures may value explicit verbal expressions of empathy, while others prioritize non-verbal cues and gestures. When employees and guests come from diverse cultural backgrounds, interactions can be complex and potentially influenced by cultural clashes and misunderstandings. By neglecting

these contextual influences, Ho and Gupat’s (2012) study draws incomplete conclusions about how culturally appropriate perspective-taking affects behaviour.

Third, this review also synthesizes the previously fragmented literature on the outcomes of empathic communication (as perceived by its recipients). As meticulously documented and organized in Table 2, I have advanced a more holistic understanding of this phenomenon by categorizing these outcomes into three distinct categories: cognitive, affective, and behavioural, devoting particular attention to the behavioural dimension as an outcome of the other two. I have also offered further granularity on the behavioural dimension by distinguishing between verbal and nonverbal behaviours.

Apart from the above contributions to the empathic communication literature, this elaboration of the nonverbal behavioural outcomes also contributes to the broader *nonverbal communication literature*. Specifically, the deductive compilation model that I developed through this review built upon the theorization of Bonaccio et al. (2016) and expanded the range of verbal and nonverbal behaviours that should be examined in service provision communication contexts. I have recorded this enlarged range of potentially pertinent nonverbal behaviours (within service-provision contexts) by adding a column to Table 2. Thus, future studies may use this supplementary column as a tool to analyze the aspects of nonverbal behaviours in further granular detail when investigating nonverbal communications. For example, Balaji, Roy, and Lassar's (2017) study revealed that when service providers communicate with clients in their second language, clients perceive interactions as less responsive, less informational, and less pleasant, potentially reducing overall satisfaction. However, this study failed to assess the impact of paralanguage and vocalics, which encompass non-verbal elements like tone, intonation, and pronunciation. An unintended or inappropriate tone can contribute to perceptions of less

responsiveness or impoliteness. These nonverbal communication factors could have provided more comprehensive insights into client perceptions, aiding service providers in improving communication strategies with second-language clients.

Finally, the resultant model contributes to the *cross-cultural communication literature*. For example, the review of empirical studies on cultural intelligence conducted by Fang, Schei, and Selart (2018) validated the significance of CQ beyond mere *hype*. It also identified several significant issues likely to shape the ongoing research discourse, such as whether cultural intelligence is a universal trait applicable across all cultures or if it varies (e.g., depending on the specific cultural context and/or the extent to which an individual can enhance and develop their cultural intelligence over time). However, the review (and the studies it examined) overlooked the potential role of empathy as a relevant accommodating factor within the broader context of cultural interactions. Their review thus failed to consider how empathy may be a potential alternative strategy for approaching communication challenges in cases where high cultural competency and prior cultural knowledge may be lacking. The model presented in this paper may help to advance this alternate theoretical explanation for improved intercultural interactions.

Limitations and Directions for Future Research

No study is without its limitations, and this study is no exception. First, while this study's literature review was thorough and systematized, it excluded grey literature such as unpublished theses or conference proceedings. Second, this review did not investigate the motivational aspect of communicated empathy, which would benefit from further empirical investigation in relation to the novel model. The third and perhaps the most important limitation of this study is that this paper did not include empirical verification. Thus, measures to tap empathy in nonverbal behaviours still require empirical testing, as none of the analyzed empirical studies conceived

measurement tools to depict enacted and communicated empathic nonverbal behaviours. Relatedly, confirmation of the utility of empathy in the absence of intercultural competencies requires empirical investigation.

The above limitations aside, below I elaborate on how this paper offers valuable directions for future empirical research that may validate both the model and address the other limitations. These suggestions are further elaborated below.

Cross-Cultural Investigations of Empathic Communication

Cross-cultural investigations of sender-recipient empathic communications are largely absent from the literature. Future investigations could benefit by reporting the cross-cultural differences in expressions and detections of nonverbal signals between senders and recipients when designing a study and reporting results (Main et al., 2017). Because empathy is not one of the universally understood nonverbal expressions of emotion (Ekman et al., 1987; Ekman & Friesen, 1971), recipients' expectations will inevitably be dictated by their cultural and religious upbringing (Hollan, 2012; Main et al., 2017). These cultural and religious differences define what acceptable behavioural expressions of empathy would look like, thereby influencing the types of behavioural cues that recipients expect and will find salient. Subsequently, recipients' perceptions of these cues will determine their cognitive, affective, and behavioural reactions, including their appraisal of their senders. This is why investigating the perspectives of culturally different groups of senders and recipients is warranted.

Exploring the Effects of Combinations of Nonverbal Empathic Cues

This review has shown that nonverbal behaviours have been inadequately investigated in empathic communications despite the calls to evaluate their effects on recipients' judgements and reactions (Chung et al., 2012). Consistent with the findings of a few studies on nonverbal

communication more broadly (e.g., Barkham & Shapiro, 1986; Bonaccio et al., 2016; Silvester et al., 2007), it is worth exploring whether (or how) different combinations of senders' nonverbal behaviours may influence perceptions of communicated empathy.

Service Providers in Vulnerable Intercultural Service-Provision Contexts

Individuals seeking empathic communication may be in vulnerable service-provider situations, such as migrant populations working in low-wage positions in a host country. These groups may miss contextual information, such as how to perform specific tasks and act appropriately, including whether they could ask specific questions. Yet, these groups would need to seek to build relationships of trust, cultural understanding, and context-specific help (Malik et al., 2014). Hence, for future research, researchers could focus on understanding specific types of vulnerable intercultural service-provision contexts that may improve accessibility and conditions (e.g., asking for assistance).

Emotional Intelligence (EQ) and/or Cultural Intelligence (CQ) As Potential Moderators?

Researchers might also investigate whether emotional intelligence (EQ) (Salovey & Mayer 1990) or cultural intelligence (CQ) (Earley et al., 2006) might serve as additional potential moderators of experiences of empathy. Neither of these constructs devotes adequate attention to the role of nonverbal behavioural cues. However, exploring their relationship to the current model could position communicated empathy within a broader nomological network of other constructs pertinent to emotional perception.

Practical Implications

Clearly, empirical validation is needed to offer fully evidence-based practical guidance for human resource interventions to inculcate interculturally empathic communication skills.

Nevertheless, the findings of this study and the theoretical implications developed offer a number of practical guidelines worthy of consideration:

First, the study's model underscores the potential role of nonverbal behaviours in enabling successful intercultural service provision experiences in different organizational settings. Hence, organizational leaders, human resource personnel, service-providing employees and others who are experiencing (or about to engage in) intercultural interactions should consider this perspective (and these factors) when interacting with cultural minorities and new societal members (i.e., new immigrants). The model's recognition of the influence of empathic communication on various recipient outcomes (e.g., recipients' physical and mental health) may help motivate this consideration. Second, it is well known that empathy is a crucial competency for promoting environmentally sustainable policies in international organizations (De Haan, 2006). Therefore, managers should recognize that attention to empathic communication may be helpful not only for the individual or the organization but also for the broader society.

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Appendix

Table 1. *Databases and Keywords Covered in the Search on Communicated Empathy*

	Web of Science	**Scopus**	**ProQuest One Business**	**Business Source Complete**	**APA PsychInfo ProQuest**
("Empathic accuracy") OR ("Judged empathy") OR ("Perceived empathy") OR ("Communicated empathy") OR ("Communication of empathy") OR ("Empathy communicated") OR ("Expressed empathy") OR ("Expression of empathy") OR ("Empathy expressed")	283	283	20	44	171
AND Method*	95	98	6	7	57
AND Measure*	84	83	7	7	70
Empathy within a five-word distance of:					
Empathy; “communicated”	4	10	1	1	3
Empathy; “perceived”	310	380	37	49	169
Empathy; “perceived” AND method*	128	165	17	8	67
Empathy; “perceived” AND measure*	101	120	6	12	73
Empathy; “judged”	4	5	1	1	4
Empathy; cross-cultur*	28	30	2	4	15
Empathy; intercultur*	34	47	6	3	8
Empathy; service employee	1	28	19	3	4
Empathy; “service provider”	4	18	10	6	7
Empathy; “customer service”	3	4	3	6	12
Empathy; “signaling theory”	0	0	0	0	0

Table 2. *Summary of Articles Included in This Review*

Authors	Journal	Research Field	Type of Sample	Publication Year	Demographics	Indicators of Empathy	Outcomes of Empathy	Why culture might matter (e.g., NVBs)
Balaji, Roy & Lassar	Journal of Business Research	Customer Service	Service Provider - Customers	2017	Age & Education on Outcome	Language Accommodation	Word-of-Mouth Intentions	-Linguistic Accommodat'n -Use of Silence -Vocalics
Derksen, Hartman, van Dijk, Plouvier, Bensing & Lagro-Janssen	Patient Education & Counseling	Healthcare	Patient Participants	2017	-	-Attitude (receptivity, commitment, authenticity) -Competency (respect, enabling, welcoming, listening)	-Safety -Trust -Commitment -Openness -Information Exchange -Coping Behaviours	-Linguistic Accommodat'n -High vs Low Context -Silence Use -Kinestics -Oculestics -Vocalics -Chronemics
Fujiwara & Daibo	Journal of Social Psychology	Education	Student Dyads	2021	-	-Posture Mirroring -Interactional Synchrony	-	-Kinestics -Oculestics
Hafskjold, Sundling, Dulmen & Eide	BMC Nursing	Healthcare	Doctor-Patient	2017	-	Verbal Responses	Information Exchange Therapeutic Relationship	-Linguistic Accommodation -High vs Low Context -Silence Use -Vocalics -Chronemics
Kraft-Todd, Reinero, Kelley,	PLOS One	Healthcare	Doctor-Patient	2017	-	-Eye Contact	-	-Kinestics -Appearance -Oculestics

Heberlein, Baer & Riess						-Equal Patient-Physician Eye-level -Physical Barriers -Posture -Facial Expression		-Haptics -Proxemics
Kraus	American Psychologist	N/A	Random Strangers	2017	-	Voice-only Communications	-	-Linguistic Accommodation -Direct vs Indirect Contact -Silence Use -Vocalics
Lord, Sheng, Imel, Baer & Atkins	Behavior Therapy	Psychological Counseling	Standardized Patients	2015	-	Verbal Matching	-	-Linguistic Accommodation -Silence Use -Vocalics -Chronemics -High vs Low Context =Direct vs Indirect Communication
Matsuhisa et al.	BMC Family Practice	Primary healthcare	Doctor-Patient	2021	Gender	Attire	-	Appearance
Meinecke & Kauffeld	Journal of Business and Psychology	Organizational Behaviour	Engineering Employees	2019	-	Verbal Matching	Intention to Change Leader's Likeability	-Linguistic Accommodation -Silence Use -Vocalics -Chronemics -High vs Low Context -Direct vs Indirect Communication
Mercer, Hig-gins Bikker, Fitzpatrick,	Annals of Family Medicine	Healthcare	Doctor-Patient	2016	Socioeconomic Status	Patient Enablement	Health Outcomes	-Linguistic Accomodation

McConnachie Lloyd, Little & Watt								-Direct vs Indirect Communication -Kinestics -Oculestics
Packard, Moore & McFerran	Journal of Marketing Research	Customer Service	Agents-Customers	2018	-	Verbal Responses	Customer Satisfaction Purchase Intention & Behaviour	-Linguistic Accommodation -Direct vs Indirect Communication -Silence Use -Vocalics -Chronemics
Parrish, Menendez, Mudgal, Jupiter, Chen & Ring	Journal of Hand Surgery	Healthcare	Doctor-Patient	2016	-	Quality vs. Quantity of Visit Duration	Patient Satisfaction	Chronemics
Sanders, Dubey, Hall, Catzen, Blanch-Hartigan & Schwartz	Cancer	Healthcare	Patient Participants	2021	-	Relationship Sensitivity (listening, respect) NVBs: Smile; Nod Procedural Behaviours: Follow-up questions; Apologies; Information sharing Competence	-	-Kinestics -Appearance -Oculestics -Vocalics -Silence Use
Seehausen, Kazzer, Bajbouj, Heekeren,	Brain and Cognition	Neuroscience	Random Individuals	2016	-	Verbal Responses	Negative Affect	-Linguistic Accommodation -High vs Low Context

Jacobs, Klann-Delius, Menninghaus & Prehn							Physiological Outcomes	-Direct vs Indirect Communication -Silence Use -Vocalics
Sternke, Abrahamson & Bair	Pain Management Nursing	Healthcare	Provider-Patient	2016	-	Listening (engaging in meaningful conversations)	Health Outcomes	-Linguistic Accommodation -Direct vs Indirect Communcation -Silence Use -Vocalics -Chronemics
Tan, Muskat & Johns	Journal of Service Theory and Practice	Higher Education	University Student-Staff	2019	-	Individualized Attention	Learning Experience	-Direct vs Indirect Communication -Kinestics -Oculestics -Vocalics -Chronemics

Figure 1. *PRISMA Flow Diagram*

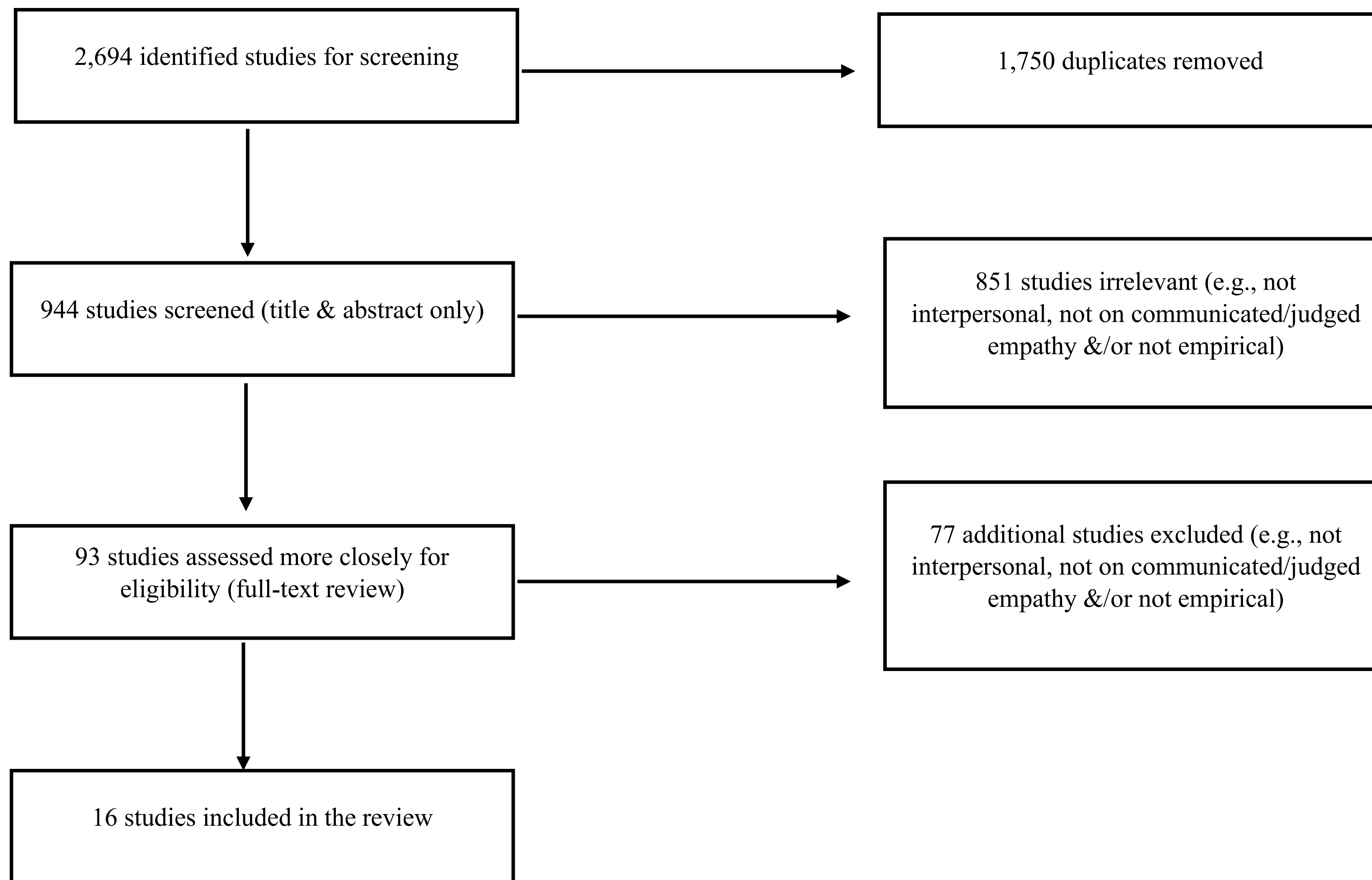
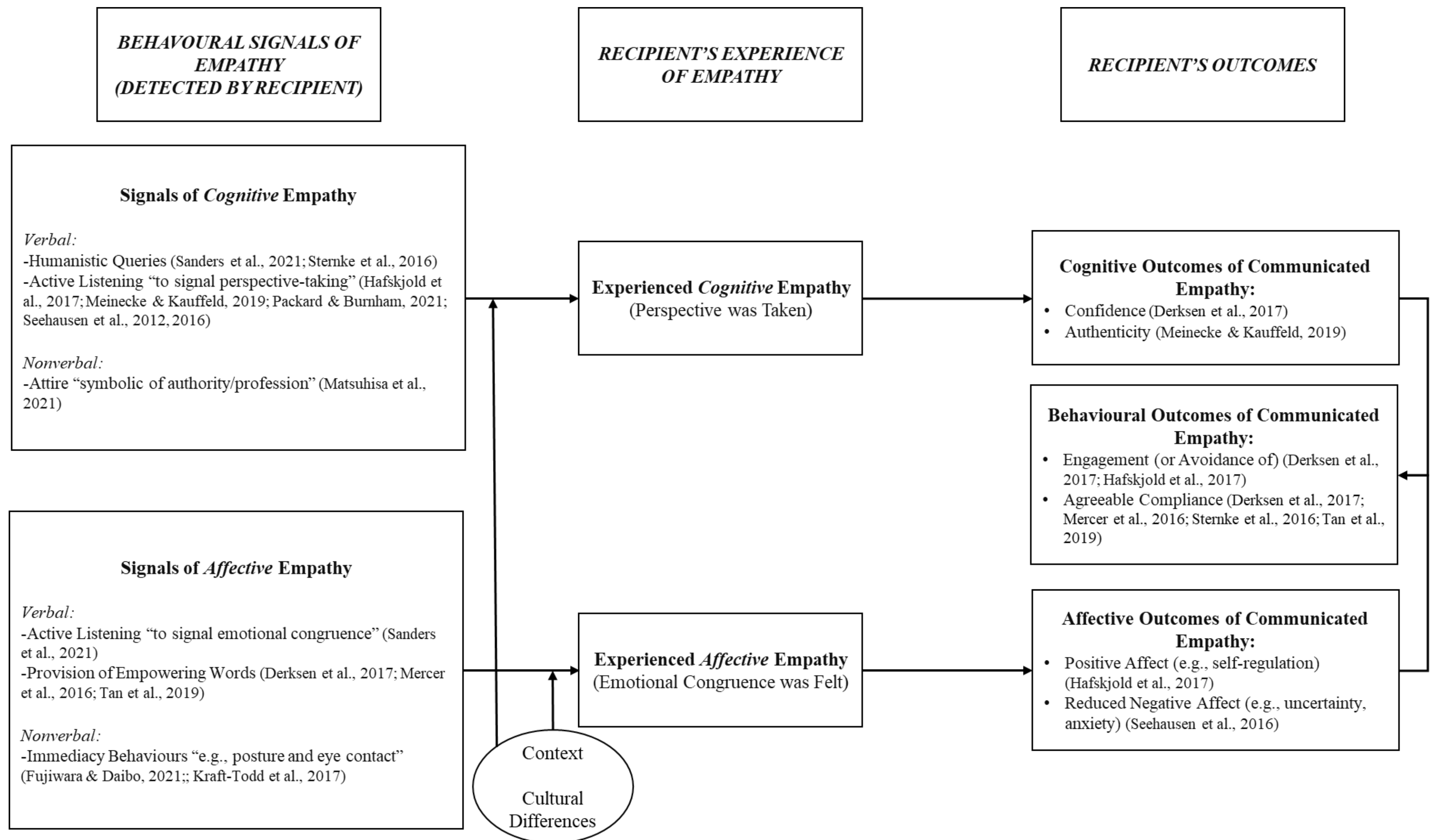


Figure 2. *The Resultant Model*



Middle Eastern Newcomers’ Experiences of Empathy in the Canadian Healthcare Context

Abstract

Globalization has significantly changed people's lives and work, facilitating global connections and communication across borders. This interconnectedness has increased diversity and interdependence among nations and societies, presenting opportunities and challenges, particularly in intercultural communication. Effective intercultural communication becomes crucial for providing quality healthcare services in the context of healthcare providers serving newcomers, such as immigrants, refugees, and international expatriates. Empathy has emerged as a valuable potential factor in intercultural healthcare interactions. However, research in this area neglected empathy recipients' perspectives and cultural differences in nonverbal cues. This study addresses these gaps by examining the experiences of empathy in healthcare communication from the viewpoint of Arabic-speaking newcomers in Canada. Interviews were conducted with thirty participants to explore verbal and nonverbal behaviours that recipients perceive as empathic and their consequences. The findings contribute to theory by enhancing our comprehension of empathic behaviours and underscoring their significance in intercultural healthcare settings. Furthermore, the study enriches the theoretical framework by expanding upon the multifaceted consequences of newcomers’ experiences of empathy, including cognitive, affective, and behavioural dimensions. On a practical level, the study serves to highlight the importance of the proactive display of appropriate empathic cues in intercultural healthcare interactions, as well as the importance of cultural empathy training for healthcare providers and orientation training for the Middle Eastern community in Canada (i.e., to assist in navigating the healthcare system more easily).

Introduction

Globalization has catalyzed how people live and work, allowing people to connect and communicate with each other regardless of where they are in the world (Maddux et al., 2021). These changes have increased the interdependence between nations and societies, leading not only to assigned expatriation (by multinational organizations) but also to economically driven self-expatriation (migration). The resulting increase in organizational diversity has broadened economic interconnectedness but has not been without its challenges: Organizations in all sectors now face a greater potential for intercultural miscommunication.

This topic is particularly timely and relevant for healthcare organizations that provide services to recently arrived newcomers. Newcomers can include immigrants, refugees, and even long-term international expatriates, defined as "anyone who has recently resettled in a new country within the past five years" (Ottawa Public Health, n.d.). Although newcomers may arrive healthy, they may not have developed the intercultural competencies to interact effectively. Yet, they must learn to communicate effectively with host country healthcare providers who may have different cultural and spiritual backgrounds and may be unfamiliar with the newcomers' cultural norms and expectations, particularly regarding healthcare services.

When poor intercultural communications result, newcomers may experience a variety of adverse health outcomes. For example, from a mental health standpoint, they may begin to experience a phenomenon known as "social liminality," in which they perceive themselves to be in a psychologically stressful, transitional state… when moving from one status or role in life to another" (Simich et al., 2009, pp. 255–258; Turner, 1969). Additional adverse outcomes can include refusing to see a provider, choosing to withhold critical health information when they do see one, failing to comply with treatments, and turning to questionable resources to seek the care

they believe they need (Ahmed & Bates, 2017; Ahmed et al., 2016; Beiser, 2005). By contrast, newcomers more capable of effective intercultural communication are less subject to these risks: They can reduce uncertainty, receive the care they need, and better integrate into their new societies (Maddux et al., 2021).

Given the importance of high-quality communication to newcomers' intercultural health service interactions, communication scholars have recently begun exploring how healthcare providers might positively influence intercultural interactions, even without culture-specific training. This has led to a focus on the utility of empathy (or lack thereof) for intercultural interactions (Ahmed and Bates, 2017). For example, Lamancuso et al. (2016, p. 429) found that newcomer refugees from Burma who resettled in the United States expressed frustration with host country nationals due to "lapses" of empathy; they regarded their host country healthcare providers as ignorant of their frustrations, insecurities, and preferences. However, Ahmed et al. (2016) posited that healthcare providers can mitigate this effect through empathic techniques.

Despite these attempts to understand the importance of empathy in intercultural communication, the validity of this stream of research for the newcomer context is constrained by several limitations: First, apart from Lamancuso et al. (2016), most studies have rarely considered the perspective of *recipients* of empathy (Ahmed et al., 2016; Laferriere & Crighton, 2017; Malik & Manroop, 2017; Malik et al., 2014). In healthcare communication, patient-newcomers represent the "recipients" of empathic communication, while healthcare providers can represent the "senders" in this process. This methodological oversight of recipients' voices fails to adequately represent the bi-directional nature of both sender and recipient in a communication encounter. Second, the empathic communication literature also lacks rich empirical data concerning the variety of verbal and nonverbal behavioural cues that contribute to

recipients' experiences of empathy (or lack thereof); this is particularly problematic given that such cues may differ across cultures. Third, it overlooks how empathic experiences (positive or negative) may, in turn, contribute to broader pragmatic consequences for recipients – whether they be cognitive, affective, or behavioural (Kellett et al., 2006).

This study addresses these gaps in the literature by exploring the recipients' perspective and asking three key questions: First, how did the newcomer recipients experience empathy in healthcare communication contexts, which - according to their view - required empathy? Second, what were the communication barriers and enablers of their experiences of empathy in healthcare communication contexts (e.g., verbal or nonverbal behaviours, etc.)? And third, how did they respond to these encounters?

This study adopted Hussein & O'Sullivan's (2020) model of communicated empathy to explore the variety of verbal and nonverbal behaviours that recipients in the intercultural communication process may appraise as empathic (or, conversely, as lacking in empathy). The model was also used as the basis to construct a semi-structured interview protocol. Interviews were conducted with thirty Arabic-speaking newcomers (recipients) from the Middle East to Canada who have frequent and intense communications with their providers (senders) due to mild health to severe/complex health concerns.

The findings of this study offer substantial contributions to the empathy theory in several key ways. Firstly, they provide fresh and valuable insights into the dynamics of intercultural healthcare contexts, shedding light on the difficulties of empathy communication. This includes a nuanced understanding of verbal and nonverbal behaviours that serve as cues for empathy and the complex cognitive, affective and behavioural consequences experienced by newcomers when healthcare providers successfully or unsuccessfully convey empathy. Crucially, this study fills a

critical gap in the literature by amplifying the voices and perspectives of recipients. Earlier research often overlooked this essential viewpoint, and by doing so, this study remedies a limitation that has persisted in the field, leading to a more holistic and comprehensive understanding of empathy in healthcare contexts. Furthermore, the qualitative nature of this study represents a significant asset. Unlike the more common quantitative approaches seen in empathy research (Clark et al., 2019)., such as paper-and-pencil surveys (e.g., Ahmed & Bates, 2017), the qualitative methodology employed here allows for a richer, more detailed exploration of the factors influencing empathic healthcare experiences.

From a practical standpoint, the findings of this study have the potential to offer valuable insights to both healthcare providers and newcomers, emphasizing the proactive display of culturally sensitive empathic cues in intercultural healthcare interactions. This information can be incorporated into training programs for two key groups: Firstly, it can enhance the training of healthcare providers, providing them with essential knowledge about effective interactional strategies when working with individuals from Arabic-speaking cultures. Secondly, this information can be utilized to orient the Middle Eastern community in Canada to the unique challenges within the Canadian healthcare system that stem from cultural differences. It can specifically draw their attention to the expectations and ways in which they should articulate their healthcare needs, thereby improving their ability to access high-quality healthcare services.

Overall, this study provides an important first step toward advancing knowledge about intercultural empathic communication. The remainder of this paper explores the theoretical foundations guiding the empirical study, the methods behind the study, and the results that emerged from it. The paper concludes with a more detailed look at how the findings inform theory and practice.

Literature Review

Globalization and the advent of communication technology have prompted nations to not only become economically interdependent but also to communicate frequently and travel to cultures other than their own (Maddux et al., 2021). Accordingly, intercultural service provision has become an increasingly common requirement in many service contexts within the global economy (Bellini et al., 2013; Ng & Metz, 2015; Ryan & Wessel, 2015).

This trend has posed unique challenges for healthcare providers aiming to provide quality healthcare to their immigrant newcomer patients (Carroll et al., 2007). For example, they are faced with newcomers who lack informational resources and language support (Ahmed et al., 2016), which results in intercultural communication and literacy barriers (Ahmed & Bates, 2017; Ahmed et al., 2016). Newcomers who struggle to communicate may suffer adverse health consequences, a phenomenon named "the healthy immigrant effect" (Lu & Ng, 2019; Vang et al., 2015), rendering their health issues more complex and, by extension, healthcare provision more challenging. Newcomer women often experience difficulties navigating the healthcare system due not only to myriad language barriers (Yeheskel & Rawal, 2019) but also – for women who adhered to clothing modesty rules for religious/cultural reasons– discrimination issues were reported in response to requests for provider-patient gender congruence (Carroll et al., 2007). This can be particularly daunting for newcomers with low health literacy (Julliard et al., 2008), ignorance of their rights, fear (Lamancuso et al., 2016) and/or low socioeconomic status (Ahmed et al., 2016; Ahmed & Bates, 2017).

Accordingly, it seems worthwhile to investigate whether/how an empathic approach to intercultural communication in healthcare contexts may assist newcomer populations. Toward this end, the following section adopts Hussein & O’Sullivan’s (2020) model of communicated

(i.e., perceived) empathy (see Figure 1) as the theoretical lens through which to explore behaviours that may be appraised as empathic (by recipients in the intercultural communication process). This particular model was selected for two reasons: First, building on signaling theory (Connelly et al., 2011) from the communication literature, it posits that empathy may be communicated via both verbal and nonverbal cues. Second, drawing on the empathy literature (e.g., Clark et al., 2019), it outlines a range of possibly important consequences for recipients of communicated empathy. Third, drawing from the cross-cultural communication literature (e.g., Molinsky, 2007), it recognizes cultural differences as a potential moderator of this process. In addition, an empirical investigation of the model offers promise for advancing our knowledge of the role of empathic communication in intercultural healthcare contexts, and for exploring the intriguing possibility that empathic communication may mitigate intercultural communication challenges, even when cultural competency and prior knowledge are lacking.

FIGURE 1 HERE

What Is Empathy?

Empathy has been defined in different ways: It has primarily been treated as an innate ability (Clark et al., 2019; Meinecke & Kauffeld, 2019) that "seems to enable people to relate to others in a way that promotes cooperation and unity rather than conflict and isolation" (Konrath et al., 2011, p. 180) and that allows people "to respond compassionately to another person's needs, motivations, or opinions by communicating their understanding." (Meinecke & Kauffeld, 2019, p. 486). Empathy has been treated less frequently as an attitude or motive that one's environment may cultivate. For example, people often learn to be more empathic with members

of their social ingroup than with outgroup members (Cikara et al. 2011). In fact, there may be both fixed and dynamic components to the capability for empathy, the former of which are based on immutable, innate traits (abilities) and the latter of which may be inculcated (Leiba-O'Sullivan, 1999).

Despite these differences in approach, it is generally agreed that the construct of empathy involves the process of putting oneself in another person's place to understand better their experiences, backgrounds, and the underlying reasons for their current states (Cuff et al., 2016; Hussein & O'Sullivan, 2020; Walter, 2012; Zaki, 2014). Scholars have also agreed that empathy is a multidimensional construct of affective, cognitive, and behavioural aspects (e.g., Clark et al., 2019; Cuff et al., 2016. The behavioural aspect, which represents the "enactment of cognitive and affective empathy" (Clark et al., 2019), is particularly interesting to this study, as it is the only observable aspect to recipients. Nevertheless, to gain a complete picture of the components of empathy and how they might influence recipients, all three aspects of the empathy construct are reviewed below.

Affective Empathy

Affective empathy, considered the most innate dimension of empathy, tends to develop earliest in individuals. Neurological studies, such as those conducted by Bernhardt and Singer in 2012, have pinpointed the specific brain regions that become active when people observe someone else's affective experiences. Interestingly, a substantial body of research in neuroscience has lent support to the hypothesis that the experience of affective empathy, as discerned from the activated brain regions in the sender, closely parallels that of the recipient, who is directly undergoing the same affective state.

This neurological observation of the mirroring effect associated with affective empathy caused some initial confusion among social science researchers because it was suggestive of emotional contagion, which arises unconsciously (Hatfield et al., 2014). This confusion has since been clarified by subsequent research: Unlike emotional contagion, the affective empathy response may manifest biologically (as in the neuro-studies), but affective empathy is *consciously* enacted. It thus denotes congruency rather than contagion (Clark et al., 2019). Hence, for the purposes of this study, which focuses on the recipient's experience, "communicated affective empathy" is defined as the recipient's recognition that the sender has *exerted an effort* to establish a compatible *affective alignment* (i.e., emotional congruency) between the sender and recipient.

Cognitive Empathy

As Davis (1983) described, cognitive empathy hinges on the capacity for perspective-taking, which involves putting oneself in another person's shoes and attempting to see the world from their vantage point. For instance, some of the items in Davis's instrument include statements like "Before criticizing somebody, I try to imagine how I would feel if I were in their place" and "I try to look at everybody's side of a disagreement before I make a decision." However, researchers have expanded on this concept, suggesting that cognitive empathy goes beyond mere imagination; it also encompasses a willingness to seek contextual cues, such as reading facial expressions (Cuff et al., 2016), to better grasp the other person's perspective. Moreover, it involves the willingness to ask questions that clarify how the other person's background and experiences might shape their viewpoint, as exemplified by Besel and Yuille's (2010) replication of Ekman's (1971) renowned experiment on universal nonverbal facial expressions, highlighting the importance of clarification to avoid potential misinterpretations.

In essence, cognitive empathy refers to both the willingness and ability to comprehend another person's internal thoughts and emotions (Clark et al., 2019). In the context of this study, which focuses on the recipient's experience, communicated cognitive empathy is defined as the recipient's perception that the sender possesses both the capacity and the willingness to make an effort to understand the recipient's internal states.

Behavioural Empathy

In many service-provision contexts, the expression of empathy is essential for effective interpersonal interaction and connection and, therefore, would be regarded as an expected aspect of the work (Cikara et al., 2011). Feeling aligned with an individual (affective empathy) or striving to discern their empathic need (cognitive empathy) yet failing to demonstrate it effectively (behavioural empathy) would represent a performance failure on the part of such service providers. Accordingly, behavioural empathy has been added as a third aspect of the empathy construct.

However, the inclusion of this third aspect has proved controversial because, as one group of researchers argue (e.g., Clark et al., 2019; Cuff et al., 2016), behavioural empathy is not an independent third dimension of empathy but rather the expression of an individual's internal cognitive and affective empathy. Although empirical research has not yet resolved this debate, the observable verbal and nonverbal behaviours associated with behavioural empathy are most relevant for this paper's purposes, as those behaviours are visible and ultimately influence the recipient's appraisal of the sender's empathy. Accordingly, behavioural empathy has been included in this paper's definition of communicated empathy. It is defined here as the recipient's experience that the sender has *displayed a combination of verbal and nonverbal behaviours* that have communicated cognitive and/or affective empathy.

Signaling Theory: A Theoretical Lens for Understanding Empathic Communication

Understanding empathic communication is best achieved through the lens of communication theory, as discussed by researchers like Clark et al. (2019), Main et al. (2017), and Zaki et al. (2008). In particular, the signaling theory of communication offers valuable insights. This theory posits that the sender, who could be an insider in the organization, possesses information crucial to a specific recipient. The sender then purposefully and explicitly conveys information or cues about this matter to the recipient. Drawing from this communicated message, the recipient proceeds with specific actions that would have been impossible without the received signal. Consequently, the Signaling theory of communication serves as a framework to delve deeper into the recipient's evaluations and reactions after receiving a signal from the sender.

Management researchers have not yet utilized the signaling theory in the context of intercultural communications (Connelly et al., 2011), let alone in the context of intercultural communication in healthcare contexts, where empathic communications may be critical. Yet, management researchers have recognized that behavioural ambiguity is inherent in interculturally diverse contexts (Elitzur & Gavious, 2003; Stiglitz, 2000), and signaling theory is relevant to addressing such information asymmetry. Thus, an investigation into the utility of signaling theory for intercultural healthcare service provision contexts is warranted for a variety of reasons:

First, little is known about the nonverbal aspects of communication that pertain to empathy (Hollan, 2012; Main et al., 2017). Despite some research progress, little seems to be known about how recipients process the myriad verbal and nonverbal cues they experience during their empathic communication encounters (Kellett et al., 2006). These omissions indicate

a broader failure to investigate the role of nonverbal communication in organizational contexts more generally (Bonaccio et al., 2016) and in intercultural contexts more specifically (Hollan, 2012; Maddux et al., 2020). Second, research neglects to recognize empathic communication encounters as bi-directional experiences: Empathy is commonly investigated from the sender's perspective with a rare exploration of the recipient's point of view. This conclusion was evident based on the systematic review conducted in the conceptual chapter.

The two shortcomings noted above were reflected in the recent review by Clark et al. (2019), which demonstrated how most studies treat empathy in a one-sided manner, soliciting the sender's perspective even when acknowledging the need to consider the recipient's experience.

Third, it is important to recognize that empathy is not universally understood as a nonverbal expression of emotion, as studies by Ekman et al. (1987) and Ekman and Friesen (1971) have shown. Instead, recipients' interpretations of empathic cues are inevitably shaped by their cultural and religious backgrounds (Hollan, 2012; Main et al., 2017). Given that different cultures and religions often have distinct norms for the behavioural manifestations of empathy, these cultural and religious influences play a pivotal role in shaping the specific behavioural cues that recipients anticipate and find significant. Consequently, recipients' perceptions of these cues greatly influence their evaluations of their senders' empathy and subsequently impact their cognitive, affective, and behavioural responses.

This study addresses these gaps in the literature by exploring the recipients' perspective and asking three key questions: First, how did the newcomer recipients experience empathy in healthcare communication contexts, which - according to their view - required empathy? Second, what were the communication barriers and enablers of their experiences of empathy in healthcare

communication contexts (e.g., verbal or nonverbal behaviours, etc.)? And third, how did they respond to these encounters?

One caveat to the above is suggested by research on cultural intelligence (CQ) (e.g., Alexandra, 2018; Ang et al., 2007; Earley et al., 2006), which has shown that an individual's CQ levels may moderate the impact of cultural differences. Individuals with high behavioural CQ have a breadth of verbal and nonverbal behaviours that they can selectively use in intercultural situations and adapt to different cultures when needed (Ang et al., 2007; Earley et al., 2006). Hence, it is equally important to acknowledge the recipient's CQ level when examining their appraisals of empathic communication. Adhering to all of the above will help to bring the recipient's perspective and voice back into research on empathy.

The following section describes the methodology by which the Middle Eastern newcomer patients (recipients) described their interactional experiences to demystify the black box of the empathic communication process from the recipient's side. Specifically, recipients were asked to narrate their positive and negative experiences with healthcare providers (senders) within the Canadian healthcare system to clarify and categorize the myriad verbal and nonverbal behaviours that enable or inhibit their appraisal of empathy. Their CQ scores were also captured for the reasons outlined above.

Methods

Methodological Approach

A qualitative and interpretive approach to inquiry (Creswell & Poth, 2018; Hennink et al., 2020) was adopted to answer the three research questions. The interpretive approach to data

collection posits that reality is socially constructed through shared meanings and sense-making of human experiences (Myers, 2013).

This study employed a combination of inductive and deductive inference approaches in its data analysis. Specifically, it utilized the communicated empathy model developed by Hussein and O'Sullivan (2020) deductively. This model served as the foundational framework for shaping the interview protocol and initially interpreting the collected data. Subsequently, after the data collection phase, emerging codes and themes derived from the data were used in an inductive manner to refine and expand upon the study's initial model.

Given the study's exploratory nature and the aim to document the quality of empathic interactions and their favourable or unfavourable antecedents for newcomers within the healthcare context, this combined approach was considered appropriate. It facilitated the generation of rich and detailed descriptions of the wide range of verbal and nonverbal behaviours that recipients perceived as cues of communicated empathy and contributed to the ongoing development of empathy theory (Eisenhardt, 1989).

Research Context

This study took place in Ontario, Canada. Generally, the Canadian healthcare system was selected as the service-provision context for several reasons:

First, Canada is an ethnic and culturally diverse immigrant-based country. Its Charter of Rights and Freedoms protects multiculturalism. Accordingly, intercultural respect and harmony are expected.

In addition, because Canadian healthcare is publicly funded, it is accessible to newcomers, and significant numbers of newcomers access the public healthcare system. More specifically, the "Ontario Health Insurance Plan" (OHIP) is a government-funded healthcare

program operating in the province of Ontario, Canada. Eligibility for OHIP hinges on factors such as residency and citizenship status, meaning that not all individuals residing in Ontario may meet the criteria for coverage. However, once eligibility is confirmed, program participants receive an OHIP health card granting them access to a wide range of medically necessary healthcare services, including doctor appointments, hospital care, laboratory tests, and specific medical procedures. The government predominantly covers the costs associated with these services, ensuring that residents can access essential healthcare without incurring direct out-of-pocket expenses for covered treatments. In the context of this study, all the participants held OHIP cards because they were either new permanent residents or convention refugees.

Participants/Sampling Protocol

A purposeful sampling strategy can inform the understanding of a specific research problem and its leading cause (Miles and Huberman, 1994). Accordingly, to address the purpose of this study, the population of Middle Eastern Arabic-speaking newcomers to Canada (i.e., immigrants and refugees) was targeted. The need to appropriately provide healthcare services to Arabic-speaking newcomers in Canada is growing in importance for several reasons. Following the eruption of the Arab Spring in 2011 and the welcoming of Middle Eastern refugees to Canada in 2015, Arab newcomers represent a growing proportion of newcomers to Canada. According to the 2016 Canadian Census, almost 1 million individuals reported having an Arabic ethnic origin, and the Arab population has increased by over 30% since 2011.

Moreover, Arabic culture is relatively distinct from the two solitudes that formed the founding cultures of Canada: Descendants of Western European Anglophones and Francophones. Hence, it offers a useful example of culturally distant interactions. Accordingly, this study explores Arabic-speaking newcomer's experiences of Canada's complex bureaucratic healthcare

system, focusing specifically on intercultural communications between Arabic-speaking patients (recipients) and their healthcare providers (senders).

Arabic newcomers with extensive and complex experiences with the healthcare system were asked to participate in data collection. Examples include pregnancy and delivery and chronic diseases requiring intense and frequent appointments. This inclusion criterion ensured sample participants had sufficient experiences to share with the interviewer and held informed perspectives about empathic interactional quality (Creswell & Poth, 2018; Miles and Huberman, 1994).

To reach the desired number of participants, I contacted several community health centers, community associations and religious associations in Ottawa through email, phone calls, and their Facebook and Instagram pages. The focal context was that of community healthcare centers in Ontario because they are dedicated to delivering comprehensive, ongoing primary care services, primarily catering to patients who require continuity of care and managing chronic conditions. These centers typically boast a multidisciplinary team of healthcare professionals capable of addressing diverse medical needs, including doctors, nurses, and specialists. Their core focus lies in nurturing doctor-patient relationships, managing chronic conditions, and promoting holistic health and well-being. In contrast, walk-in clinics excel in providing immediate, episodic care for minor illnesses and injuries, all without the need for prior appointments. While they offer a convenient avenue for prompt medical attention, walk-in clinics do not facilitate continuity of care or establish ongoing patient-provider relationships.

A brief message about the study and the type of participants required was provided, asking them to circulate the study's information to their visitors/clients. It is worth noting that data collection took place during the 2020-2022 pandemic, at a time when many institutions had

temporarily closed. Hence, of the 23 centers and associations approached, only nine places responded, but eight (all were community health centers) agreed to circulate the study's message among their visitors. The one that declined (a mosque) did not give any reason for its refusal to participate in the study. Two of the eight participating centers asked for a printout of the study's recruitment message, and I delivered it to the centers' receptionists. Interested persons contacted me directly, and interviewed participants were asked to circulate the study among their social network (e.g., family and friends). Accordingly, the participants were recruited through combined purposeful and snowballing sampling techniques.

Thirty Middle Eastern Arabic-speaking newcomers with frequent intense interactions with the Canadian healthcare context were interviewed, which is deemed enough to reach meaning saturation (Hennink et al., 2017) to capture the newcomers' experiences and perspectives sufficiently. Table 1 in the Appendix presents an overview of the participants' demographic data, and this table is discussed further in the results section.

TABLE 1 HERE

Data Collection Procedure

Semi-structured interviews with open-ended questions were used for data collection. This method was deemed appropriate to the purpose of the study as the goal was to gain a detailed emic (i.e., culturally specific) perspective on communicated empathy as felt and experienced by its recipients (Hennink et al., 2020).

Interviews were conducted by phone. Despite some concern about the weaknesses of conducting interviews over the phone versus face-to-face (Hennink et al., 2020), there were

several compelling theoretical and practical reasons for not using video interviewing in the context of this study:

First, the primary goal of the study was to gain insight into the participants' subjective perceptions and reflections on their past lived experiences. Video interviews could introduce complexity by inadvertently signaling my nonverbal cues in the present context, which may distract from the study's central objectives of focusing on participants' reflections on the dynamics of past communication exchanges. By opting for phone interviews, the focus remained on the participants' narratives and interpretations, allowing for a more direct exploration of their experiences.

Second, phone interviews are as effective as face-to-face interviews in terms of capturing participants' paralanguage, which includes elements such as pauses, variations in tone and emphasis, and repeated phrases or words. Such paralinguistic cues provided insightful nuances of emotional expression during the interviews without distracting the participants with the interviewer's nonverbals. This paralinguistic information was effectively noted, providing richer insights into the participants' emotional states and emphases during their narratives. At this point, it is worth acknowledging that the verbal language used in expressing emotions may also hold implications for research outcomes, as cultures vary in their position along the cultural value dimension of high versus low context communication styles, as delineated by Hall (McKay-Semmler, 2017). Specifically, low-context cultures are typified by direct and explicit verbal communication and tend to express emotions through language overtly. Conversely, high-context cultures rely on a subtler interplay of non-verbal behaviours, contextual cues, and shared cultural meanings in their communication. In this regard, Arab cultures, emblematic of high-context communication styles, diverge from North American culture, which predominantly emphasizes

the explicit content of verbal communication. Having said this, it is equally emblematic of Arab communication norms for emotions to be overtly conveyed through paralanguage, which refers to tone, pitch, rhythm, pause, and intonation, alongside contextual factors and shared cultural references. This intricate blend of verbal and non-verbal elements facilitates expressing and interpreting emotions within Arab contexts. Thus, although phone interviews cannot detect kinesic nonverbals, they capably detect these paralinguistic nonverbal nuances.

A third pragmatic reason that phone interviews were used is that the study involved a vulnerable population, and it was essential to ensure accessibility and inclusivity in the research process. Phone interviews proved to be more convenient for the interviewees' privacy, budget, and schedules. Many participants lacked access to the technology, knowledge, and/or financial resources required for video calls. Some participants did not even have email addresses, necessitating the use of traditional mail for sending consent forms. Employing video interviews would have created barriers for these individuals, potentially excluding them from participation and compromising the study's inclusivity and diversity.

Finally, phone interviews also ensured the health and safety of all participants. This was particularly important amidst the Covid-19 outbreak.

The interviews, on average, lasted approximately 40 minutes each. Additionally, a brief survey was distributed via email to gather essential demographic and behavioural cultural intelligence (CQ) information relevant to the cultural aspects of the study. The survey was also conducted over the phone for participants who did not have email addresses, and responses were recorded in an Excel spreadsheet.

The interview protocol (see Table 2) was constructed using a critical incident technique (Flanagan, 1954). The questions covered general impressions and reflections of participants

interacting with providers in the Canadian healthcare context. They also encouraged participants to share their stories of specific, significant positive and negative experiences, including probing how participants made sense of the visible verbal and nonverbal empathic cues and how their interpretations of these visible/audible aspects of the communication process may have guided their subsequent experiences and appraisals (of empathic interactional quality) and their behavioural reactions. The questions had to be based on retrospective participant recollection, as there was no opportunity or access to observe the communication encounters as they occurred. Finally, participants were asked to share their views on whether/how improved empathic communications could increase the quality of care for their particular population. Two participants (6.67% of the sample) were more comfortable speaking only in general terms about their appraisals of their interactions with several providers without specifying particular positive or negative incidents per se.

Throughout data collection, the interview protocol was revised by concept checking, paraphrasing, and clarifying points via discussions with the thesis advisor about the first few interviews conducted. In addition, new questions were introduced to probe consistently emerging themes (Spradley, 1979).

TABLE 2 HERE

The mother tongue of all participants is Arabic. However, the interviews were conducted in English or Arabic based on their preference and/or English proficiency. The interviews were digitally recorded, transcribed verbatim, and translated from Arabic to English when needed. Following the final transcription, participants were contacted for review, and they received both

the audio recordings (for the Arabic interviews) and transcripts (for the English interviews) for their verification. Participants were asked to report any modifications they wanted within fourteen days of receiving the recording/transcript.

Steps to Ensure Trustworthiness and Rigour

My perspective and strategies to mitigate bias played a crucial role in interpreting the data, as they enriched the depth and authenticity of the study in several ways:

First, my personal experience as a newcomer gave me a deep understanding of the challenges and emotions that individuals in the sampled population might have encountered. This empathy allowed me to connect with them on a profound level. It enabled me to ask relevant and sensitive probes, which captured nuanced insights that a cultural outsider might have missed. My background also contributed to my commitment to giving a voice to the Arab population to ensure the research's social relevance and impact. Hence, I remained diligent in data collection and analysis, allowing participants to share their experiences and challenges authentically. This latter point was further facilitated by my mother tongue proficiency in Arabic.

Second, to ensure academic and institutional receptivity to the study's findings, I rigorously adhered to the literature-derived questions in the interview protocol to ensure the trustworthiness of the data collection procedure and data analysis. I maintained consistency across all interviews, reducing potential bias that might have arisen from variations in the interview process. This methodical approach ensured that all participants had an equal opportunity to share their experiences. The thesis advisor, who was not of Arabic background, reviewed initial English-language transcripts and provided feedback, adding an extra layer of critical objectivity to the data collection and analysis processes. For example, during the analysis,

the advisor's insights helped identify areas where additional probing about assumptions was warranted, effectively enhancing the study's rigour.

Finally, although member checking of the data interpretations was not conducted as systematically as it could be, participant verification was conducted in the sense that interviewees were provided with verbatim transcripts to facilitate their corrections and additional elaborations to the raw data; this was critical in ensuring the fundamental trustworthiness of the raw data itself. This approach also allowed participants to directly contribute to interpreting their experiences, ensuring their perspectives were accurately represented.

Data Analysis

I adhered to the principles of grounded theory (Strauss & Corbin, 1990) and followed the procedures of Gioia, Corley, and Hamilton (2013) in building theory from qualitative data. I coded the data manually with the help of an Excel spreadsheet.

I did a first pass of the first-order coding and then consulted their supervisor. We discussed and resolved any coding uncertainties (e.g., needed more contextual detail to code or needed to find a more appropriate English language word to capture an Arabic expression) until we reached a full agreement (e.g., the full transcripts were reviewed up to four times following the first-cycle coding). At least 50% of the data were co-coded. These comparisons helped develop the codebook as well as decide whether to retain, revise (e.g., renaming codes or creating new codes), or discard them. Likewise, we did the same for the second-level codes, which tapped emerging themes about experiences of communicated empathy (Hennink et al., 2020). For example, the interviewed participants repeatedly described shortcomings in the healthcare system and the interventions used to overcome them. These observations were initially coded as experiences of communicated cognitive empathy but then later re-coded as

external moderators of their experience of communicated cognitive empathy, as it became clear that they more accurately constituted systemic barriers and enablers in the appraisal of communicated empathy. In the next phase, I connected first-order concepts to second-order themes by categorizing them according to cognitive aspects (thought processes) or affective aspects (emotions). Afterwards, the data demonstrated that the communicated empathy experienced by participants led to different implications (i.e., different responses: cognitive, affective, or behavioural). Finally, an expert in qualitative research on the thesis committee revised the data structures and offered some suggestions. The final data structure is provided in Figure 2. Arrows in the figure denote connecting first-order codes to second-order themes to higher-level theoretical dimensions.

FIGURE 2 HERE

Results

Descriptive Findings

Participants' Demographics

Thirty individuals agreed to talk about their experiences in intercultural healthcare contexts in Canada, where the healthcare provider was from a different cultural background. Interviews lasted, on average, 40 minutes. Table 1 shows that the participants were all newcomers to Canada, either refugees or immigrants. The number of years that participants had lived in Canada at the time of the interview ranged from 2 to 5 years, with an average of 4 years. Almost half of the participants immigrated from Egypt, followed by Syria (11 participants). Two-thirds of the sample were females. Further examination of participant demographics did not yield

discernible patterns significantly related to the narratives of experiences conveyed by the study's participants.

Participants' Behavioural CQ

Half of the sample (15) had a medium level of behavioural CQ, while ten scored low and five individuals scored high on behavioural CQ. After further analyzing the participants' responses according to their level of behavioural CQ, some interesting insights emerged. For example, over 80% of those who reported moving to Canada five years ago continued to score low-medium on behavioural CQ. This was the case even among those with extensive previous experience with foreigners in Canada and/or abroad (57% of the participants). In other words, participants did not experience a significant shift in their level of behavioural CQ despite spending more time interacting with people from different cultures in one or more host countries.

Choice of Provider

Four of the thirty participants had no choice of provider, which was assigned to them. Of the remaining twenty-six, fourteen took an ethnocentric approach to their choice of provider (i.e., choosing someone who spoke Arabic or based on cultural community recommendations). At the same time, twelve used a pragmatic basis for their decision (i.e., based on proximity or accessibility, as in provider accepting new patients/walk-ins).

When these results were broken down by levels of behavioural CQ, it was found that eleven of the fourteen (78.6%) ethnocentric choices were made by low-medium behavioural CQ scoring participants, while three of the fourteen (21.4%) ethnocentric choices were made by high behavioural CQ scoring participants.

In addition, a significant proportion of participants, 66.67%, expressed that medical interpretation services were unnecessary during their appointments. Among this group, 13

individuals shared varied experiences with healthcare providers in Canada, which encompassed both positive and negative encounters. It is also worth noting that among the subset of participants who frequently utilized medical interpreters, only two reported solely negative experiences.

The Intensity of Intercultural Healthcare Encounters

All participants noted that they see healthcare providers for significant health issues for themselves or a family member (e.g., a partner, child or older adult). They generally agreed that their interactions in the healthcare context are challenging due to the novelty of the cultural context that creates uncertainty. More specifically, they noted cultural differences in norms and behaviours, language limitations, lack of experience in and knowledge of how the healthcare system works, and accessibility difficulties as the roots of their communication problems and primary reasons for their frustration and adverse reactions.

Findings from the Data Analysis

The analysis demonstrated a spectrum of outcomes arising from the empathic experiences of participants. It was surprisingly apparent that reports of positive experiences were limited. Instead, participants reported a predominance of negative and challenging encounters within healthcare service provision. The analysis also revealed several enablers and barriers that influenced the quality of the recipients' empathic interactions. These critical findings have been thoughtfully incorporated into the communicated empathy model, which is presented in Figure 3.

I report the findings in three sections, aligning with the previously established research questions. In the first section, the focus is on how participants vividly described their empathic experiences. The second section delves deeper into the barriers and enablers identified by participants, shedding light on the cues they used to assess the quality of empathy in their

intercultural interactions with non-Arab healthcare providers. Finally, in the third section, I explore the behaviours participants employed in response to empathy or to negotiate empathy when the situation demanded such adjustments actively. It is worth noting that attention to the barriers participants faced and their responses allows us to understand the nature of these challenges and how recipients exercised their agency to overcome them. It also enables us to consider the spectrum of interventions, in terms of policies and practices, that can effectively address these barriers and positively impact the overall empathic experience of recipients. It is worth noting that, for some quotes, contextual information was omitted to ensure the confidentiality of the participants.

FIGURE 3 HERE

RQ1. How Did the Recipients Experience Empathy in Healthcare Communication Contexts?

Recipient-patients pointed to their experiences of cognitive empathy following the depiction of specific behavioural cues with culturally embedded elements (as I will discuss in the barriers and enablers section). Participants reported experiencing cognitive empathy, where they perceived that healthcare providers showed interest in their situations through perspective-taking. This form of empathy was evident in statements such as *"I felt that they (the provider) did not want me to be in pain" (RIMM10, female from Egypt, 4 years in Canada)*. This quote suggests that participants perceived that the healthcare provider's actions conveyed a genuine concern for their well-being, with a focus on understanding and addressing their pain.

Participants also pointed to the providers' behaviours of actively seeking humanistic information about them, actively listening to their complaints, and offering help as contributing

to their experience of cognitive empathy: *"They always tried to understand and help me" (RIMM12, female from Syria, 5 years in Canada)*. Finally, participants highlighted the holistic nature of cognitive empathy, which goes beyond addressing medical symptoms and emphasizes the importance of recognizing patients as individuals with unique experiences and emotions: *"I felt they (the provider) were good on a human level" (RIMM13, female from Egypt, 5 years in Canada)*. This quote implies that healthcare providers could connect with the recipient on a fundamental human level, transcending the clinical aspect of care.

In contrast, some participants did not experience cognitive empathy in their healthcare encounters with providers who did not actively engage in perspective-taking, listen attentively, or offer the kind of support that would have eased their concerns: "I did not feel completely fine or confident during the consult" *(RIMM18, female from Syria, 5 years in Canada).*

In addition, in my exploration of cognitive empathy, it is noteworthy that for some participants, the experience of cognitive empathy was not hindered by visible ethnic backgrounds or cultural differences. As one participant expressed, *"I did not feel they (the provider) were treating me differently (in a negative way) because I was veiled or Arab" (RIMM9, female from Egypt, 5 years in Canada).*

In addition to the shared experiences of cognitive empathy, the study also reflected on their encounters with affective empathy during their interactions with healthcare providers. Affective empathy encompasses understanding and actively demonstrating care, emotional comfort, and the provision of hope. These aspects contribute to a holistic and patient-centred approach to healthcare, ultimately enhancing the overall healthcare experience, especially in vulnerable and challenging healthcare situations. The participants' descriptions of feeling comfortably cared for highlight the importance of affective empathy in healthcare settings. One

participant expressed, *"Emotionally, I felt comfortable" (RIMM21, female from Egypt, 5 years in Canada).* This statement encapsulates the essence of affective empathy. It suggests that the healthcare provider's behaviours created a safe and comforting emotional space for the patient. Another participant noted, *"They showed that they care for me" (RIMM8, female from Saudi Arabia, 5 years in Canada).* This statement highlights that some patients often seek more than just clinical expertise; they also recognize and value healthcare providers who actively demonstrate their care. A third participant stated, *"They have never hurt me (emotionally) and always tried to give me hope" (RIMM6, male from Syria, 2 years in Canada)*. This quote underscores the positive emotional impact healthcare providers can have on patients. Emotional support and instilling hope can be powerful aspects of experiencing affective empathy.

Thus, as perceived by recipient Arab patients, perspective-taking and emotional connection contributed to their experience of communicated empathy with their healthcare providers. These experiences ultimately enhanced the patient outcomes, as will be discussed later (when I address the third research question).

RQ2. What Were the Barriers and Enablers to the Recipients' Experiences of Empathy in Healthcare Communication Contexts?

As participants reflected on their past experiences and shared their narratives, they pointed to several enablers and barriers (cues) that influenced their evaluation of empathy in their intercultural healthcare encounters. This section delves into two primary categories of cues: Cognitive signals and affective signals of communicated empathy. Some of the participants' comments pertained to categories that were previously depicted in the literature and discussed in

the conceptual paper, such as humanistic queries as a cognitive cue. Others pointed to new categories, such as providers demonstrating offering help behaviours.

Furthermore, the focus of this study was intercultural encounters within the healthcare context. Hence, particular attention is paid to the shared experiences with culturally embedded elements. This focus allows us to recognize the complexity of such encounters and how the perception of Arab patients plays a significant role in appraising empathic experiences. For example, two participant quotes, *"Their (the provider's) body language made me feel confident" (RIMM13, female from Egypt, 5 years in Canada)* and *"These things (specific verbal and nonverbal behaviours) made me feel like you know, they do care" (RIMM10, female from Egypt, 4 years in Canada)*, exemplify the significance of these cues in shaping the empathic experience for Arab patients. The following sub-sections elaborate on these findings and provide some examples with illustrative quotes.

Cognitive Signals of Communicated Empathy. This section describes the different cognitive displays of communicated empathy as perceived by recipients. The cognitively empathic cues were grouped into Humanistic queries, adopted from the conceptual paper, and Offering help behaviours, a new category that emerged from the narratives provided by the participants.

Humanistic Queries. As marked by the participants, humanistic queries encompassed providers (senders)seeking humanistic information about their patients (recipients) that tap into their personal and emotional aspects. These inquiries signalled that providers aimed to understand their patients holistically, beyond their medical conditions, contributing to more empathic care. In other words, these senders did not hastily ascribe the recipients' state/behaviours to their internal characteristics (i.e., lack of effort/inabilities/flawed personality

traits). Genuine interest in the recipients' personal history and lifestyle appeared to increase communicated empathy as one participant noted: *"I did not feel like I was being judged when he (RIMM13's child, who was the patient) acted out" (RIMM13, female from Egypt, 5 years in Canada)*.

However, participants mostly experienced a lack of providers taking a health and cultural history check and acknowledging and utilizing it. One participant expressed frustration, stating:

> *"They (the provider) did not want to look in the history folder I prepared, even when I insisted that they had to because I have a long history and cannot explain everything" (RIMM11, female from Egypt, 4 years in Canada).*

Another participant highlighted the need for providers to engage more with patients and make them feel comfortable by establishing a deeper understanding of their individual needs and concerns.

> *"I need them (the provider) to communicate more with the patient (the participant talking about themselves in the third person) and make them feel more comfortable. For example, the provider should be aware of my personal details on file during the visit and also ask me, but that is not always the case here (in Canadian healthcare context)" (RIMM17, female from Syria, 5 years in Canada).*

A third participant raised concerns about healthcare providers' lack of knowledge about the patient's medical history and cultural background, which necessitates collecting and utilizing health and cultural history information.

> *"They should know more about my medical history and what is common in my country of origin. For example, many providers do not know what vaccines I took as a child. They do not know what the common medical problems I face. They do not have an idea about the medical issues and common diseases I have in my country; they do not study them. They do not know enough about Middle Easterns" (RIMM26, male from Egypt, 5 years in Canada).*

The neglect of the recipient's broader context in healthcare interactions was perceived to lead to problematic internal attributions made by the provider. For instance, one participant shared a concerning experience.

> *"They (the provider) said to me, 'You smoke, so you have money to buy cigarettes, then you can buy this medicine'... I felt that they meddled in my personal affairs. Although I am visiting a doctor to help me give up smoking but, they did not know that and did not ask me" (RIMM6, male from Syria, 2 years in Canada).*

The above example illustrates how a lack of consideration for the patient's broader context and specific healthcare challenges can lead to misconceptions and judgments on the provider's part. In this case, the provider made an internal attribution regarding the patient's financial priorities based solely on their smoking habit, without considering the patient's underlying reason for smoking and seeking medical assistance – to quit smoking.

Furthermore, some participants perceived that the propensity for healthcare providers to make internal attributions was compounded by what they perceived as cultural bias. One participant shared their experience, highlighting the complexities of healthcare interactions in

intercultural contexts: The perception of being treated differently or unfairly due to one's cultural background can lead to frustration and a sense of self-doubt.

> *"I felt like they acted this way only with me, like… Did I do something wrong? They (the provider) were a four-star provider (on Google reviews), which is not bad at all. So yeah, I was frustrated with maybe, I do not know, maybe it is a cultural thing… Maybe they feel anyone from my background (Arab culture) is always over-complaining medically" (RIMM10, female from Egypt, 4 years in Canada).*

> *"I felt they (the provider)were trying to learn more information to ensure that I'm treating my children well compared to my cultural background, experiences or history. It may be a common question, but I felt that they are investigating me more than doing their job" (RIMM20, male from Egypt, 5 years in Canada).*

> *"I am veiled, and I do not know if they (the provider) were asking me these questions because I am veiled, and they think all veiled women are subject to violence, or they ask everyone without discrimination. On every visit, they asked me if I was subject to violence at home, and they kept asking me about my personal life, mainly when I visited them alone" (RIMM22, female from Egypt, 5 years in Canada).*

At the same time, participants also indulged in internal attributions about their sender-providers. When they did so, it helped explain their lower empathy experience. For example, one participant attributed the provider's reluctance to make a specialist referral to what they perceived as the provider's stubbornness:

"Do not be stubborn about it (participant speaking about their provider). They (RIMM10 talking about patients such as themselves in the third person) do not need someone to be dismissive of their pain; they need someone to have empathy, listen to them and take their pain seriously… So, genuinely try to help or if you cannot, or, you know, will not or whatever, refer me to someone who can" (RIMM10, female from Egypt, 4 years in Canada).

Offering Help Behaviours. Recipients recounted numerous behaviours exhibited by senders that enhanced or hindered their perceptions of communicated empathy. A comprehensive summary of these helping behaviours, along with illustrative quotes, can be found in Table 3 in the appendix. Below, I present selected examples – of senders' efforts to mitigate language barriers and demonstrate cultural competence – with illustrative quotations.

TABLE 3 HERE

On minimizing language barriers, participants recalled experiences where providers demonstrated sensitivity to their language limitations and provided translation assistance. These experiences highlighted the importance of providers being attuned to the linguistic needs of their patients and taking proactive measures to ensure that language barriers do not hinder the patient's understanding of crucial medical information and to display a commitment to effective communication. These efforts were highlighted in the following example:

> *"They (the provider) asked about my native language, and then they sent me an Arabic version of the correspondence and informational resources I needed or was supposed to receive. They provided an Arabic copy for those who do not know English or it is not their mother language. They accommodated this cultural difference" (RIMM15, female from Egypt, 2 years in Canada).*

On demonstrating cultural competence, participants highlighted behaviours senders exhibited to adapt to cultural differences (i.e., gender or religious practices). When senders demonstrated cultural sensitivity by inquiring about the recipients' preferences in their care, recipients acknowledged their senders' respect for their cultural norms and comfort levels, contributing to a more empathic and patient-centred healthcare experience. For example, on gender congruence preferences, one participant said:

> *"I was doing a blood test, and the provider asked me if I needed a same-gender provider to do the test. I was also asked if I have specific preferences for the specialists I need to meet; they asked us if I prefer them to be women or men. I have been asked this question many times" (RIMM21, female from Egypt, 5 years in Canada).*

However, participants pointed to experiencing lower cognitive communicated empathy when they interacted with senders who lacked awareness of the recipient's cultural values and their impact on intercultural communication. These encounters were categorized using Hofstede's framework for cross-cultural communication, and a comprehensive list can be found in Table 4 in the appendix.

TABLE 4 HERE

I present a selected example below on uncertainty avoidance. It is noteworthy that uncertainty avoidance tends to be relatively high in the Arab culture. This means that generally, Arab individuals prefer structured and predictable situations. Accordingly, they prefer familiar routines and well-defined situations, which seemed to be the opposite of what they found in the Canadian healthcare context.

> "*We (Arabs) come from a culture where I go to the doctor, who usually prescribes medicine or refers me to someone or, like, you know, tries to explain what is going on… I do not like when someone does not explain what is happening. Like, like, you know, I have a basic level of education, you know, I have a Master's degree, I can understand if you explain the medical term, or if you Google something and show it to me, or if you try to explain what is going on… Also, in my country, I go to see a specialist right away; I do not have to go through a family doctor and then convince the family doctor that I need to see a specialist, and then I am under the mercy whether they refer me or not. So culturally, I am just used to going to the place that will heal me, and that is it" (RIMM10, female from Egypt, 4 years in Canada).*

Affective Displays of Communicated Empathy. Participants pointed to diverse manifestations of affective displays of communicated empathy as perceived by them. This section delves into two primary categories: Verbal active listening behaviours and Nonverbal *culturally considerate* immediacy behaviours.

Verbal Active Listening Behaviours. Participants associated their experiences of affective communicated empathy with instances where senders utilized verbal affirmations to express their active listening. These verbal affirmations, combined with evidence-based reassurance, enhanced recipient comfort and fostered a sense of mutual understanding and emotional connection.

> *“She (the provider) understood how hard it was. You feel like it (the consult) turned into a human development session. She encouraged me by saying, ‘I know how hard it is’ and that gave me the motivation to continue (treatment and coming to subsequent consults)” (RIMM13, female from Egypt, 5 years in Canada).*

> *“When she (the provider) found me worried (after revealing a serious diagnosis), she tried to comfort me by saying that it happens to a high percentage of pregnant women and that she would help me to treat it” [(RIMM15, female from Egypt, 2 years in Canada).*

Furthermore, recipients described a strong sense of affective empathy when senders employed empowering language or sentences during their interactions. In these instances, senders actively acknowledged the recipients’ emotions and encouraged them to connect with their own sense of agency and take an active role in their healthcare decisions. For instance, one participant recalled a provider's approach, stating, *“Some providers were like, 'How can I help? How can I make you feel better?' And I really liked when one provider asked me, 'Are you in pain? I can get you more pain medicine'” (RIMM10, female from Egypt, 4 years in Canada)*. This empathetic approach empowered the recipient by acknowledging their needs and offering immediate solutions, creating a collaborative and supportive healthcare environment.

Similarly, another participant shared an experience where the provider used a highly accommodating approach: *"She (the provider) used the approach of 'What do you want? What is your goal? If you want 50/50 (breastfeeding and formula), this is what we will work on; If you want 100% breastfeeding, this is what we will work on.' She was very accommodating to what I wanted" (RIMM13, female from Egypt, 5 years in Canada).* In this case, the provider's open dialogue and willingness to tailor the healthcare plan to the recipient's preferences fostered a sense of agency and partnership in the decision-making process.

However, there were instances when senders used empowering statements that inadvertently hindered affective communicated empathy. In these situations, recipients felt overwhelmed or unsupported because they were asked to make crucial healthcare decisions independently without a sense of collaboration, partnership, or guidance from their providers. These instances seemed to make the cross-cultural differences apparent. Examples of participants expressing frustration include:

> *"The provider asked me, 'Do you want me to give you antibiotics?'; I do not know if I have to take antibiotics, which is why you (the provider) are here examining me. You are the one who should know!... I tell them (the providers) that I do not know (the participant's response to the provider's questions). You are the Doctor who should know how to solve my problem; I will not tell you what is wrong with me and what to prescribe" (RIMM18, female from Syria, 5 years in Canada).*

> *"She (the provider) gave me the option to decide which medicine to take. She gave me three brochures for different types of medication and asked me to choose. I do not have the experience to do that... I feel that culture affects the way they (the providers) interact with*

us. They are afraid to force Canadians to do anything, and I think we (Arabs) are the opposite. I do not feel comfortable making the decision (alone)" (RIMM26, male from Egypt, 5 years in Canada).

Furthermore, participants also recounted instances where they perceived lower levels of affective communicated empathy. This was primarily attributed to the senders' failure to paraphrase the main points raised by the recipients during the interaction. Paraphrasing involves summarizing or restating what the recipient has communicated, demonstrating active listening, and ensuring mutual understanding. In some cases, participants experienced frustration when the senders did not accurately paraphrase their main points or paraphrased without allowing the recipients to clarify their points further. This lack of effective paraphrasing hindered the establishment of emotional connection and mutual understanding.

"When I finally saw the second provider, he told me carelessly, 'Well, we all have back pain'… I cannot say there was a mutual understanding when I tell the provider: 'Doctor, I cannot sit, I have not been sitting for the past 5 or 6 months!' And the provider responds, 'You know what, let us wait and see you again in 3 months'… Three months later, I return: 'Doctor, I cannot sit' and again the provider responds: 'Let's wait another month...' (RIMM3, male from Tunis, 3 years in Canada).

"They (the provider) were not actually listening to me. They were dismissive or just gave me general feedback that they give to everyone… I would tell them that a specific medication is not working or that I used to do so in the past and it was not working. But

they still insist that 'No, like, stay on this treatment or this regimen, and that is what you are supposed to do'" (RIMM8, female from Saudi Arabia, 5 years in Canada)

"The last time I went to the provider, I had high blood pressure, and I went to him saying my blood pressure readings were high. Still, he said, 'No, it is under control; it is just a little bit above average, and that is fine.' He did not listen. I wanted to tell him more details… A provider (RIMM24 talking in general) can show empathy by repeating the patient's concerns like 'I understood you, right?' or 'Is this what you mean?'. Anything like that, you know, because what I mean matters" (RIMM24, male from Kuwait, 5 years in Canada).

"He (the provider) always comments on my condition without asking enough questions to confirm with me" (RIMM6, male from Syria, 2 years in Canada).

The recipients' narrated experiences showed similarities between the senders' paraphrasing behaviours and the provision of empowering words. These similarities were significant enough to warrant consolidating them into a single category – Verbal Active Listening Behaviours, rather than maintaining two separate categories as demonstrated in the conceptual paper.

Nonverbal Culturally Considerate Immediacy Behaviours. Participants shared instances in which providers displayed nonverbal behaviours that positively influenced the quality of their empathic interactions. More specifically, recipients described situations in which the providers demonstrated an understanding of cultural norms related to modesty. The generally shared principles of modesty include: Modesty in dress is highly emphasized. Arab men and women are

expected to dress modestly, which typically means covering the body, especially in public. For women, this often includes wearing loose-fitting clothing that covers the arms, legs, and hair (hijab) and modesty in gender interactions. This can involve avoiding physical contact between unrelated men and women, especially in public. It also includes speaking respectfully and avoiding inappropriate language or topics.

> *"Men (nurses/technicians) covered my body and treated me very respectfully as a veiled woman when I had the (procedure). They also helped me and held my hands in case I needed help getting up, only if I asked" (RIMM12, female from Syria, 5 years in Canada).*

> *"The provider who performed my (procedure) used to knock on the door before entering my room to give me a chance to wear something (her hijab) in case I needed to. It was clear he was aware of this cultural difference" (RIMM15, female from Egypt, 2 years in Canada).*

Conversely, the absence of this specific cultural sensitivity greatly hindered the expression of communicated affective empathy. While senders may genuinely intend to convey empathy and comfort, their actions may inadvertently breach cultural boundaries and create discomfort for the recipients. As pointed out below by RIMM22, although well-intentioned, the provider's empathetic gesture was directed toward the wrong individual (a veiled woman) and expressed in a manner inconsistent with cultural and religious expectations. (female from Egypt, 5 years in Canada):

"They (the provider) should know they cannot touch a veiled woman, for example. They cannot touch her, even if they think it is a kind of showing empathy. They show empathy, but with the wrong person or in the wrong way, you know. I do not know how to behave in such a situation, but I try to keep a distance. This is a cultural as much as a religious issue."

In addition, participants reported experiencing affective communicated empathy when providers employed various aspects of nonverbal communication, including oculesics (eye contact), kinesics (body movements), and vocalics/paralanguage (voice tone and pitch). These nonverbal cues played a significant role in conveying empathy. Oculesics: Participants highlighted that when providers maintained appropriate levels of eye contact, it positively influenced their perception of empathy and the quality of the interaction because it signified that the provider is fully present and focused on the patient's needs and concerns.

"I appreciate it when they (the provider) looked me in the eye and tried to explain and gave me their attention" (RIMM10, female from Egypt, 4 years in Canada)

"... to always look me in the eye to ensure I follow and understand whatever he/she is saying... I do not know how to explain it, but definitely not staring... the normal amount you need in a conversation, when I am talking to him/her and when he/she is explaining to me at least" (RIMM11, female from Egypt, 4 years in Canada)

Furthermore, participants shared instances of kinesics, which refer to nonverbal communication through body movements, including posture, gestures, and facial expressions, that

providers utilized, which enhanced their perceived empathetic communication. On posture: Participants noted that a relaxed and approachable posture was seen as a positive cue for empathy. For example, one participant mentioned, *"She (the provider) was soft (relaxed). Not someone rigid with me or made me feel that the interaction was too formal or there was too much distance. Her posture made me feel she was confident" (RIMM13, female from Egypt, 5 years in Canada)*.

On gestures: Participants appreciated senders who used gestures to aid in their explanations to make complex information more accessible.

> *"She (the provider) used hand gestures a lot to explain my condition" (RIMM2, female from Syria, 5 years in Canada).*

> *"He (the provider) tried to explain to me using his hands… After the checkup, he pointed to my waist, so I understood that I had a problem there" (RIMM5, male from Syria, 2 years in Canada).*

On facial expressions: Participants recounted positive experiences when providers smiled and displayed comforting facial expressions. A smile, in particular, was seen as a simple yet powerful way to convey emotional connection and comfort during the interaction. For instance, one participant mentioned, *"They (the provider) smiled… A simple smile for me was enough" (RIMM10, female from Egypt, 4 years in Canada)*.

Finally, participants emphasized the significant role of paralanguage (speech) and vocalics (voice qualities) in their experiences of affective communicated empathy, particularly in situations

where language posed a barrier to effective communication. Participants appreciated providers who were responsive to their language needs and adjusted their speech accordingly, particularly when English was not the native language. For example, one participant noted:

> *"She (the provider) speaks fast, and I usually ask her to slow down to understand her… She then tries to speak slowly and uses easy words so I can understand her" (RIMM2, female from Egypt, 5 years in Canada).*

> *"I felt them (the provider) talking slowly to help me understand what they say, especially when they learned that my native language is not English" (RIMM15, female from Egypt, 2 years in Canada).*

Conversely, participants recalled instances where the lack of adjustment in vocalics and paralanguage hindered their experience of affective communicated empathy. In this case, the uniform tone and approach in delivering positive and negative information were perceived as lacking empathy. One participant expressed disappointment, stating, *"They (the provider) used to tell me the bad news in the same way and tone they tell the good news… They had no empathy… They were very cold" (RIMM22, female from Egypt, 5 years in Canada)*.

In summary, the narrated experiences of cognitive communicated empathy demonstrated that recipients found comfort in senders who actively sought humanistic information, listened attentively, and offered assistance, fostering mutual understanding. However, they encountered lower cognitive empathy when senders failed to inquire about their health and cultural history, hindering effective communication and relationship building.

Regarding affective communicated empathy, recipients appreciated verbal active listening behaviours, such as empathetic verbal affirmations and empowering language that acknowledged their feelings and encouraged a sense of agency. Nevertheless, perceived affective empathy suffered when senders posed decisions without clear collaboration, failed to paraphrase the recipients' main points, or neglected cultural awareness, resulting in unempathetic interactions and decreased emotional connection.

Systemic Moderators. As participants delved deeper into their shared experiences, they identified various systemic healthcare factors that played a crucial role in shaping their perceptions of the quality of empathic interactions. Some of these factors enhanced their experiences of communicated empathy, making their integration into these healthcare interactions smoother. In contrast, participants also pointed out aspects of the healthcare system that hindered their experiences, exacerbating their challenges in an unfamiliar environment. These systemic factors have been incorporated into the communicated empathy model as moderators that influence the overall empathic experience. The following quotes are presented to provide a comprehensive understanding. It is important to note that some of these moderators affect the experiences of everyone interacting with the Canadian healthcare system, not just Arab newcomer patients, such as the long waiting time, booking delays, low GP accessibility and delayed feedback from consults.

Effort at Patient Inclusion. Efforts at patient inclusion within the healthcare system emerged as a pivotal enabler in healthcare interactions. It involved active initiatives by the healthcare system to ensure patients felt welcomed and valued, thus fostering a sense of belonging and comfort. This inclusivity enhanced the quality of empathic exchanges and contributed to overall positive healthcare experiences as perceived by the Arab patients. These

enablers included universal and free healthcare, interactive online messaging platforms, and personalized care.

> *"We came from Lebanon (refugee camp). My daughter (the patient) was nearly eight months old when I was there. They (the provider in Lebanon) asked me for a large sum of money to perform her surgery, but I did not have enough money, so I could not make it. I can have the surgery here for free!" (RIMM19, female from Syria, 3 years in Canada)*

> *"I love that my provider has an email or an application system where we can exchange messages because reaching them on the phone is like Mission Impossible. So, at least if I can email them or send them a message on their secure system, I can send it at a time that is convenient for me, and they can answer at a time that is convenient for them" (RIMM10, female from Egypt, 4 years in Canada)*

> *"With every single appointment, the provider at the center did all the checkups on my son (the patient), went through the care plan and ensured that our (personalized) plan was going well for my son and me" (RIMM13, female from Egypt, 5 years in Canada)*

Lack of Orientation. On the other hand, participants highlighted systemic shortcomings that significantly detracted from their experiences of communicated empathy. These shortcomings appeared rooted in the participants' lack of orientation to the healthcare system. Many struggled with navigating the complexities of the healthcare system, leaving them feeling uncertain and vulnerable. This lack of guidance and information compounded their difficulties in evaluating the quality of empathic care, ultimately hindering their ability to engage in healthcare

interactions fully. These identified shortcomings were categorized into nine different topics, listed in order of frequency in Table 5 in the appendix, with sample quotes provided below.

TABLE 5 HERE

> *"Here (in Canada), we are totally lost; we do not know where to go to receive specific healthcare services. We came to Canada two years ago, but we still know nothing" (RIMM5, male from Syria, 2 years in Canada)*

> *"My biggest problem is that when I moved to Canada as a newcomer, I did not know how to navigate the healthcare system… Knowing whom to go to and for what takes me a very long time. How do you go about things, and how do you access the information? Maybe because I did not grow up here, I do not know how. I feel I must work extra on it so I can find information whenever I need something. I also do not know how to find it by myself easily. There are many great available services, but no one speaks about them or they are unclear. I think it is important to make the information more accessible or to make newcomers at least know what is available for them in the healthcare system and how to navigate it" (RIMM13, female from Egypt, 5 years in Canada)*

RQ3. How Do Recipients Respond to These Encounters?

This section provides insights into the diverse responses that recipients employed following their assessments of interactions as either empathic or deficient in empathy. In instances where recipients perceived a lack of empathy, they were compelled to experiment with

various verbal and nonverbal behaviours to elicit empathy from their healthcare providers during these interactions. It is important to note that participants often found it challenging to pinpoint whether their responses directly resulted from experiencing cognitive or affective communicated empathy or a combination of both. The following sub-sections are organized based on the categories initially presented in the communicated empathy model from the conceptual paper: Cognitive, affective, and behavioural responses.

Cognitive Responses. Recipients experienced various mental responses experienced in intercultural communication within healthcare interactions. They often pointed out that healthcare providers demonstrated empathy through perspective-taking, paraphrasing, and employing culturally appropriate immediacy behaviours. For example, perceived communicated empathy heightened the perceived confidence in the sender. Recipients felt assured and valued, knowing that their concerns would not be dismissed, particularly when there were potential health issues at stake:

> *"I am confident and have been lucky with the providers I went to… It feels good to know that they will not ignore me if there is a possibility of something suspicious and will validate my concerns" (RIMM13, female from Egypt, 5 years in Canada)*

> *"She (the provider) was confident in her conversation, making me confident in her with no concerns" (RIMM15, female from Egypt, 2 years in Canada)*

Furthermore, recipients emphasized that these empathic experiences fostered trust in their providers. When providers took the time to explain medical information and demonstrated competence, it contributed significantly to building a sense of trust:

"When the providers take the time to explain everything, and they seem to know what they are doing, it makes me trust them more" (RIMM11, female from Egypt, 4 years in Canada)

On the other hand, the lack of experiencing communicated empathy hindered the creation of a trusting connection. The following quote exemplifies the recipient's reaction after interacting with a sender who attributed the patient's unhealthy behaviour to internal flaws and neglected to adequately paraphrase the patient's statements or seek additional medical history.

"I do not trust him (the provider) …" (RIMM6, male from Syria, 2 years in Canada)

Moreover, empathic experiences often led to recipients respecting their providers, especially when providers acknowledged cultural and religious aspects during interactions. This respect stemmed from the providers' promotion of shared human values, irrespective of religious background:

"They (the providers) promoted human values in society based on coexistence regardless of religion… This is a positive side of experiencing their care, making me trust them with my treatment" (RIMM12, female from Syria, 5 years in Canada)

Additionally, recipients respected providers for showing cultural sensitivity: *"Clearly, he (the provider) was aware of the cultural differences... I respected that" (RIMM15, female from Egypt, 2 years in Canada)* through actions like substituting handshakes with alternative greetings and using simple phrases in the patient's native language:

"When they (the providers) put their hands above their heart to thank you (instead of a handshake), I respect them when they do this… They also use simple Arabic words as a sort of respect; I respect that, too, and appreciate it" (RIMM9, female from Egypt, 5 years in Canada)

"When they (the provider) gave the accompanying support person (family member, spouse) attention and respect, I respect them for doing that (because family is important to include in the interaction)" (RIMM8, female from Saudi Arabia, 5 years in Canada).

In summary, the mental responses of recipients in intercultural healthcare interactions encompassed feelings of confidence, trust, and respect, illustrating the profound impact of healthcare providers' empathic behaviour on the patient-provider relationship.

Affective Responses. This section delves into the emotional outcomes that recipients experienced when they recognized communicated empathy from their senders. As detailed below, the discussion is organized into two primary categories: Positive and negative affect. It is important to note that, as previously mentioned, participants predominantly recalled challenging and less empathic experiences. Hence, the positive affect category captured all positive resultant emotions akin to the initial communicated empathy model. However, participants did not point out instances that led to reduced negative affect. Instead, they shared experiences that ended with them developing negative feelings, as will be discussed shortly.

Positive Affect. The few instances recipients shared pointed to positive emotions resulting from perceived empathic interactions, including happiness, satisfaction, and relaxation. These emotions were collectively categorized under the concept of "Contentment." Recent findings

from positive psychology research have shown that contentment arises from an individual's positive assessment of their current circumstances and is associated with reduced physiological arousal and immediate relaxation responses (Cordaro et al., 2016).

"I usually come out of my visit to the neurologist quite satisfied" (RIMM2, female from Syria, 5 years in Canada).

"I was relaxed during my pregnancy care (after visits with the provider)" (RIMM15, female from Egypt, 2 years in Canada)

"I was happy and at ease after talking to them (the provider)" (RIMM7, female from Syria, 5 years in Canada)

Negative Affect. The negative affective responses described by recipients following experiences of lower communicated empathy shed light on the emotional toll such interactions can have on Arab newcomer patients. These responses were categorized under "Helplessness," signifying that patients often felt powerless and overwhelmed by the lack of empathy in their healthcare encounters.

"I felt a lot of stress after my appointments last month" (RIMM2, female from Syria, 5 years in Canada)

This quote reveals that inadequate experienced empathy during medical appointments may lead to heightened stress and anxiety. Recipients may worry about their health or the effectiveness of the treatment plan, which may exacerbate their existing health concerns.

"Honestly, I felt very frustrated, and I felt like I was trapped" (RIMM10, female from Egypt, 4 years in Canada)

This quote underscores the frustration when recipients perceive a lack of understanding or support from their providers. This feeling of being "trapped" suggests that recipients may have difficulty expressing their needs or concerns, leading to a sense of powerlessness in the healthcare system.

"I ended up feeling distressed… I felt that I did not have the right to decide what to do with my body" (RIMM14, FEMALE FROM Egypt, 5 years in Canada)

This quote highlights the distress and loss of autonomy experienced by some recipients. When experienced empathy is lacking, recipients may feel disregarded or disrespected, particularly regarding decisions about their bodies and healthcare choices.

Behavioural Responses. ***Agreeable Compliance.*** Participants highlighted that experiencing cognitive and affective communicated empathy has led to them following the providers' care advice in healthcare. This category illustrates what was termed the "agreeable compliance" behavioural responses of the recipients. This term implies that patients are more likely to follow through with prescribed treatments, medication regimens, lifestyle changes, and appointments when they perceive that their healthcare providers are responsive to their needs, concerns, and preferences. Recipients closely linked agreeable compliance to effective communication, demonstrated cultural competence, and a positive patient-provider relationship.

"These two situations (examples of communicated cognitive empathy) showed that she (the provider) cares and sees me like a family member... Whatever she asks me to do, I do it" (RIMM21, female from Egypt, 5 years in Canada)

> *"It (display of affective empathy) left a good impression on me, and I attended all my appointments with the providers afterwards" (RIMM13, female from Egypt, 5 years in Canada)*

On the other hand, the lack of communicated empathy has led recipients to resist the paternalistic role of the sender-provider. They justified their non-compliant response because they perceived that the provider forced them to accept recommendations without understanding their thoughts and feelings or acknowledging their concerns.

> *"I was like, 'No... You need to listen to what I am saying… So, I am refusing to perform this test!'" (RIMM10, female from Egypt, 4 years in Canada)*

> *"I refused to do the procedure, and I did not do it at all till now! (three years later)" (RIMM14, female from Egypt, 5 years in Canada)*

Avoidance of Engagement. This category describes several behaviours participants demonstrated following their experience of lower communicated empathy. These responses reflect the participants' attempts to disengage from or avoid further interactions with healthcare providers they found lacking empathy. The motivation for these behaviours was to receive more empathetic and effective healthcare and to avoid further negative interactions with providers recipients perceived as lacking in empathy. It is worth noting that I did not elicit any examples of positive engagement from the participants.

Some participants chose to leave their medical appointments prematurely. This decision was driven by their frustration or dissatisfaction with the ongoing interaction. They felt that the appointment was not productive or beneficial, leading them to terminate it abruptly: *"I then left the appointment. I left mid-appointment because I felt that it was not going anywhere" (RIMM3, male from Tunis, 3 years in Canada)*.

Other participants expressed their intention to avoid scheduling future appointments with the providers they perceived as lacking empathy. This decision was made to spare themselves from similar negative experiences in the future: *"I did nothing actually (to voice their concerns during the consult), but during my appointment, I already had decided in my mind not to come back" (RIMM11, female from Egypt, 4 years in Canada)*.

In addition, some participants sought alternative sources of help and support. These sources included seeking care from different healthcare providers, consulting their (non-medical) cultural communities, or exploring options outside the Canadian healthcare system. These alternatives were pursued to find more empathetic and understanding caregivers.

> *"Honestly, what I did was I tried to book an appointment on a day when the provider (who was not empathic) was not there at the clinic. And it worked!" (RIMM10, female from Egypt, 4 years in Canada)*

> *"After my interactions with the provider, I now try to avoid going to them, and I consult someone I know (from the cultural community) or take painkillers (independently) instead. It is better for me to stay home than go to a consult" (RIMM1, female from Yaman, 3 years in Canada)*

"I talked to two clinics in the States and flew to Germany to see a doctor because I lost trust and hope in the Canadian healthcare system" (RIMM3, male from Tunis, 3 years in Canada)

Proactive Intervention. This last category describes deliberate behaviours that recipients undertook in response to poor or unsatisfactory experiences of communicated empathy in a healthcare interaction. Participants pointed out that they proactively used these corrective measures to improve the empathic quality of their interactions with senders. This category was further divided into self-advocacy during the interaction, researching after the interaction and using strategies to game the healthcare system.

Self-Advocacy during Consultation. Participants recounted examples of how lower empathic experiences led them to actively engage in discussions with their sender-providers. Participants spoke up about their concerns, rights and needs, such as proactively asking clarification questions and expressing their thoughts. They used different strategies based on their language literacy and personal situations. Illustrative examples regarding self-advocating in English (i.e., when language was not a barrier) are presented below. Other illustrative quotes are presented in Table 6 in the appendix.

"*I ask, like, I ask questions. I keep on asking for what I need until it is resolved… The thing is, like, it is not all about the providers; it is about the patient. The patient needs to be able to, like, if they have questions, they should be able to ask or feel to question anything regardless of how the provider is" (RIMM8, female from Saudi Arabia, 5 years in Canada)*

"I had a problem with the food; that is a cultural issue they (providers) must respect. I asked for Halal food, but they told me that it is not available… On the first day, they brought me an ordinary meal, but I did not eat the meat. After that, they brought me Kosher meals, which were okay" (RIMM15, female from Egypt, 2 years in Canada)

TABLE 6 HERE

Consultation Research after Initial Visit. Some participants discussed behaviours they adopted after their initial consults and before future visits. They believed these behaviours would improve the quality of communicated empathy in subsequent interactions.

Information Seeking from External Sources: Participants actively sought information from external sources, such as the Internet, to educate themselves about their medical conditions, treatment options, or related topics. This information-seeking empowered them with knowledge and enabled them to engage more effectively in conversations with their providers.

"I searched and looked up things and went to the provider and asked him if he could give me this (suggested treatment), and he was like, 'Yeah yeah, that's an option!'" (RIMM3, male from Tunis, 3 years in Canada)

Preparation of Questions and Statements: Another repeated behaviour involved the preparation of a list of questions, concerns, or statements before the next appointment. This preparation ensured that individuals could clearly communicate their needs and preferences, making the most of their limited consultation time, particularly since they perceived that their providers expected them to come prepared with questions and information.

"The provider's attitude is that if I did not ask or did my research before the appointment to find the right questions, they do not offer the information… I prepared the questions before all my checkups while pregnant or at my kid's checkups. If I do not go prepared, I do not feel that there is someone who will offer the information or tell me what to look out for" (RIMM13, female from Egypt, 5 years in Canada)

Adaptation to the Healthcare System: Several participants adapted to the healthcare system by proactively seeking help or assistance, such as asking friends or acquaintances for translations or explanations related to their health concerns. This adaptation allowed them to overcome language or communication barriers and effectively communicate with their providers.

> *"I have asked for the help of a friend of mine who is a teacher here to tell me the names of specific body parts and symptoms in English. If I want to go to the provider again, I must prepare and practice what I want to say before I call their office. I had to adapt to the system instead of changing it" (RIMM16, female from Syria, 5 years in Canada)*

Gaming the Healthcare System. Finally, recipients described attempts to manipulate or navigate the system to overcome its perceived barriers and meet a sender-provider with more empathic tendencies. Particularly, recipients underscored two behaviours: calling the clinic repeatedly (even for "provider shopping") and utilizing the ER for nonemergency reasons.

Calling the Clinic Repeatedly (Provider Shopping): Recipients resorted to repeatedly calling their family doctor's office or healthcare clinics with the hope that they will connect with a healthcare provider who is more understanding or willing to offer them an appointment, even if it is a brief one conducted online or over the phone.

"Sometimes, I call my family doctor's office again and again and ask for treatment. Maybe someone will answer the phone, understand the situation, and give me an early appointment with my provider or a different one, even if for five minutes online or over the phone" (RIMM7, female from Syria, 5 years in Canada)

Utilizing the Emergency Room (ER) for Nonemergency Reasons: Some recipients visited the emergency room for healthcare issues that are not emergencies. This is often done when they feel that their regular provider's appointment is too far in the future and believe they need more immediate care.

"I got sick a while ago; it was not serious, but I headed to the ER for immediate care because my provider's appointment was too far" (RIMM2, female from Syria, 5 years in Canada)

Exaggeration in the ER: Another behaviour that pertained to visiting the ER for nonemergency reasons was exaggerating or embellishing symptoms and conditions when visiting the emergency room. Recipients may do this to ensure they receive prompt attention, as they fear their condition might not be taken seriously if they accurately describe their symptoms.

"I go to the ER, and I need to exaggerate! Even if the pain was 7/10 and then it eased off to be 5/10, I would still say it is 7/10. I would not say I lie, but I exaggerate… I have to make some noise in the ER; you can throw up in the corridor, show that you are in pain, and scream as loud as you can! It is like:'"Do you sneeze?' (provider asking), 'Yes, I do' (patient responding), 'Do you feel a tremble?' (provider asking), 'Yes, I do!' (patient

responding),. You always have to exaggerate and say yes to everything" (RIMM25, male from Egypt, 5 years in Canada)

In summary, participants' behaviours varied in response to their perceived experiences of empathy and systemic barriers. Self-advocacy during consultation highlighted the importance of patients actively engaging in their care. After the initial visit, consultation research demonstrated patients' proactive efforts to become better informed and prepared for provider interactions. On the other hand, gaming the healthcare system revealed strategies individuals employed to navigate system limitations or perceived shortcomings, even if these strategies sometimes involved unconventional practices. These behaviours shed light on the recipient-patients' determination to elicit empathy from their sender-providers and to meet their healthcare needs. In the next section, I discuss the findings in light of the literature.

Discussion

Summary of Key Findings

Along with globalization, intercultural communication is rising and is here to stay (Maddux et al., 2021). Although the cross-cultural management literature is rich with studies that explore the challenges of intercultural communications and the integration of newcomers in their host nations (Malik & Manroop, 2017; Malik et al., 2014; Simich et al., 2009), the focus has primarily been on how to deliver a clear message interculturally, with relatively little attention devoted to either the empathic quality of the message or to recipients' thoughts and emotions about that empathic quality. Indeed, research on empathy in intercultural communication is still in its infancy (Clark et al., 2019; Cuff et al., 2016).

Accordingly, this study has attempted to fill this void by taking a closer look at empathic messaging in intercultural communication. In addition, given that intercultural communication represents an interpersonal process, the recipient's perspective was deemed to merit closer attention when analyzing intercultural communication. More specifically, the purpose of this study was to expand our understanding of the various ways in which empathy is detected and experienced interculturally and to explore the consequences of that experience of communicated empathy for the recipients and their organizational service contexts. Accordingly, 30 interviews were conducted with Middle Eastern newcomers to Canada who have frequent interactions with service providers in healthcare.

Overall, the findings identified behaviours on the part of the healthcare providers (i.e., the senders in the communication process) that were either facilitative or obstructive in the newcomers' (i.e., the Middle Eastern patients, who were the recipients) experiences of communicated empathy. In addition, several systemic barriers and facilitators emerged to provide further insight into how empathy is communicated via the healthcare system. For example, the findings about the utilization of medical interpretation services emphasize the potential contribution of medical interpretation services in minimizing communication barriers and improving the empathic quality of interactions within healthcare settings.

In addition, the findings suggest that individuals with high CQ did not exhibit a significant difference in the perceived quality of empathic communication compared to those with low or medium CQ, as demonstrated in Table 1 (column Nature of shared experiences vis-à-vis behavioural CQ category). This finding is surprising, considering that high CQ is often associated with better intercultural understanding and communication skills (Earley & Ang, 2003). However, even individuals with high CQ may vary in their natural disposition or aptitude

for empathic communication. Hence, participants may perceive that they excel in their behavioural CQ but not necessarily demonstrate it in empathic communication. Moreover, the context in which the participants interacted may influence the quality and perception of empathic communication. Different cultures may have varying expectations, communication styles, and norms regarding empathy. Hence, participants may have struggled to navigate the specific cultural expectations around empathy in this patient-provider healthcare context.

More specifically, regarding the first research question, which explored participants' *experiences* of both communicated cognitive empathy (i.e., where the sender engaged in perspective-taking efforts) and communicated affective empathy (i.e., where the sender was emotionally congruent with the recipient to understand the latter's emotional state), the results indicated that varying degrees of both types of communicated empathy were experienced. Recipient-patients indicated they recognized instances where the sender-providers engaged in perspective-taking efforts, where they tried to understand their thoughts, feelings, and perspectives. These instances involved active listening, asking clarifying questions, and/or showing genuine interest in the recipient's experiences. Additionally, recipients also reported experiencing varying degrees of affective empathy through verbal and non-verbal cues; the senders conveyed empathy by mirroring the participant's emotions, expressing understanding, and providing emotional support. This emotional congruence appeared to foster a sense of connection and support, making participants feel heard and validated in their emotional experiences.

Concerning the second research question, which explored the enablers and barriers of participants' experiences of communicated empathy, results indicated that both verbal and nonverbal behavioural cues were essential to the experience of communicated empathy, which

provides more depth to the findings of previous research (Chung et al., 2012; Silvester et al., 2007; Seehausen et al., 2012, 2016). Previous studies did not provide a sufficient understanding of the nonverbal behaviours that influence empathic judgements (let alone recipient assessments), as they were mainly quantitative studies which used ratings to tap empathy. Hence, this study advances existing knowledge by richly describing the behavioural cues which influence the assessment process. It also offers external validity via examples from real encounters in service provision contexts.

In so doing, the study reveals that two categories of sender-provider behaviours greatly facilitated positive appraisals of communicated cognitive empathy (i.e., (1) seeking humanistic information and (2) offering help), which includes making cultural and religious considerations. These findings underscore the importance of senders' openness to being culturally considerate by accommodating the cultural and religious needs of the recipients in the appraisal of the empathic quality of interactions. They also concur with previous findings (e.g., Raine et al., 2010; Sanders et al., 2021; Sternke et al., 2016)

Concerning their appraisal of affective empathy, recipients underscored two main categories of nonverbal behaviours as key facilitators. Initially, active listening behaviours by the sender-provider, including the sender's capacity to paraphrase and ensure the accuracy of the messages sent and received, coincide with previous research (e.g., Carroll et al., 2007). However, a second category later emerged. The data further clarified that participants also seek several culturally appropriate immediacy behaviours, manifested in how senders utilize eye contact, posture, and other nonverbal behaviours. The study contributes to the theory of communicated empathy as it provides a comprehensive understanding of the behaviours exhibited by service provider-senders and perceived by patient-recipients as acts of cognitive and affective

communicated empathy. By doing so, the findings shed light on the participants' thought processes and the specific behaviours they desired in their interactions with service providers.

In addition to the findings related to individual behaviours and interactions, the findings also revealed emergent insights about the influence of systemic healthcare factors on the experience of communicated empathy. Participants identified several aspects of the healthcare system that impacted their access to services and their perception of the empathic quality of the interactions. For example, positive factors included patient-centred care, which refers to an approach where healthcare providers prioritize patients' needs and preferences, involve them in decision-making, and tailor care to their specific circumstances. Recipients of patient-centred care are more likely to feel understood, respected, and empathically supported. This finding may support Ahmed and Bate's (2017) conclusion that patient-centeredness significantly reduces the recipient-patiens' concerns about service providers.

On the other hand, participants also noted negative factors within the healthcare system, such as a lack of orientation for newcomers, which adversely affected the recipients and led to various negative responses. Several recipients noted that they were accustomed to a different healthcare system in their home countries and were unfamiliar with the processes and norms of the system in Canada. Yet, they did not receive any orientation or support to help them navigate the system and find the care they needed. They encountered language barriers, cultural differences and appointment scheduling issues, which impeded the experience of communicated empathy and, in turn, motivated the recipient to avoid using the healthcare system altogether. This chain of events, which at times led to the recipient's avoidance behaviour, provides some evidence for the phenomenon known as the "healthy immigrant effect," which refers to the pattern where immigrant populations, who may have better health upon arrival, experience a

decline in their health outcomes over time due to barriers in accessing healthcare services (Kennedy et al., 2015; Vang et al., 2015). Namely, this study helps to identify the process by which this occurs.

Finally, the third research question focused on the consequences of participants' experiences of communicated empathy. Earlier studies by Kellett et al. (2006) suggested that a range of cognitive, affective, and behavioural outcomes could be expected. This study builds upon this earlier work by revealing not only which outcomes arise but also the nature of those outcomes, as well as how these outcomes are interrelated.

More specifically, cognitive responses were reported following experiences of communicated cognitive empathy. Recipients appraised the senders as trustworthy, reliable and capable when the sender validated their inputs during the communication process. These findings concur with the limited previous research on recipients' cognitive responses (e.g., Chung et al., 2012). Additionally, the study's findings reveal that when the sender demonstrated awareness of cultural beliefs and practices and made culturally appropriate considerations, recipients reported respect towards the sender.

In addition, affective responses were reported due to the varied degrees of communicated affective empathy experienced by the participants. Unlike previous studies that primarily focused on neurotechnology and investigation of the emotion-centered areas of the brain (Seehausen et al., 2012, 2016), this research delved into the recipients' own descriptions of the affective consequences they experienced (which were categorized into two main categories: positive "contentment" and negative "helplessness"). Positive affective responses were characterized as "contentment" because participants reported feelings of happiness and satisfaction concerning their empathic interactions and experiences with provider-senders. Feeling understood,

supported, and cared for by the sender elicited a sense of contentment, leading to positive affective responses. On the other hand, participants conveyed feelings of anger and powerlessness where they felt less communicated empathy from the provider-senders. The absence of understanding, support, and care during these interactions contributed to a sense of helplessness, resulting in negative affective responses. These findings add a novel voice to previous research that was sender-led (e.g., Hafskjold et al., 2017), neuro-based (e.g., Seehausen et al., 2012, 2016) or quantitative (e.g., Silvester et al., 2007).

Finally, this study sheds additional light on the spectrum of behavioural responses resulting from experiencing varying degrees of communicated empathy. The combined experience of cognitive and affective communicated empathy (or lack thereof) influenced recipients' behavioural responses. For example, following lower levels of communicated empathy, recipients not only failed to comply with treatments but also refused to see healthcare providers withhold critical health information during interactions and turned to questionable resources for seeking the care they believed they needed. Other recipients described engaging in proactive behaviours such as overflowing the emergency room or creating noise in their sender-providers' offices. These behaviours were employed during or after an interaction with healthcare providers and were intended to 1) navigate the complexities and bureaucracy of the healthcare system (in light of the lack of orientation), 2) draw attention to the recipients' needs and 3) elicit an empathic response from the sender-providers.

Another emergent finding was that many participants were not content to sit back and suffer the consequences when communicated empathy was low. Rather than be mere passive recipients in the communication process, they actively responded by engaging in proactive behaviours to influence their experience of communicated empathy. Clearly, however, such

attempts to 'game the system' can adversely affect the healthcare system, such as increasing wait times and causing resource strain (Huyer et al., 2018). Indeed, in pediatric care, excessive visits to the emergency room for low-acuity health issues have been identified as a problem (Huyer et al., 2018), as participants visit the emergency room unnecessarily due to excessive worrying or limited knowledge of when it is appropriate to seek emergency care. These adverse responses align with some of the findings reported by previous studies (e.g., Ahmed & Bates, 2017; Ahmed et al., 2016; Beiser, 2005; Derksen et al., 2017; Mercer et al., 2016; Sternke et al., 2016; Tan et al., 2019). However, this study's findings offer a more comprehensive understanding and depiction of the various behavioural responses that recipient-patients enact during and after interactions where they perceived less or a lack of communicated empathy from their sender-providers.

The above insights are relevant for understanding the overall intercultural communicated empathy process and its consequences for the recipients of empathy as well as for their organizational service contexts. These findings built upon our existing literature, including a literature-derived deductive model (Hussein & O'Sullivan, 2020) to produce an emergent (abductively formulated) model of communicated empathy (see Figure 3 below).

Overall, the data supporting our revised model underscores the importance of attending to experiences of communicated empathy. Hence, it is important to balance empowering patients to advocate for their needs and ensuring the appropriate utilization of healthcare resources. Overall, the study's findings highlight the need to address systemic barriers and improve healthcare providers' capacity to deliver empathic care in order to mitigate recipients' resorting to such behaviours.

FIGURE 3 HERE

Theoretical Contributions

This study makes several tangible theoretical contributions:

First, this study represents a pioneering approach to empathy research by shifting to the foreground of the neglected voices of the recipients of empathy. This marks a new direction in this field of study as, traditionally, much of the empathy research has centred on the perspective and behaviours of the empathy sender and how individuals convey empathy to others. Tapping into the lived experiences and perspectives of those directly affected by empathic interactions thus allows for a more holistic examination of empathy as a social phenomenon (encompassing both the sender's intentions and the receiver's interpretations), which is particularly important for service-oriented intercultural work contexts.

This study theorized and found that empathy recipients’ perspectives matter, and their responses and proactive interventions signal their need for empathic help. By shifting this focus in the empathy literature, this study not only fills an important gap in perspective but also raises new questions about the validity of findings from previous studies. For example, in a study by DeCelles et al. (2018), service employees' empathy toward clients in customer service situations was measured through surveys. The results of that study showed that following exposure to various situational and physiological stressors they might face during provider-client interactions, service providers reported higher perceptions of client anger and fear. This led to increased empathy and slightly more intended helpfulness toward their clients. The scholars concluded by emphasizing the role of organizational training in helping employees perceive

clients' distress and respond with supportive behaviours. However, these findings would be incomplete without incorporating the client's perspective. We miss out on crucial insights without considering how clients perceive the antecedents that lead to identifying these stressors, how they interpret and evaluate the empathetic behaviours displayed by providers, and whether the assistance provided is perceived as genuinely effective. By not addressing these aspects, we may fail to accurately understand the criteria that clients employ to assess empathy's quality and authenticity and determine their needs and expectations. This understanding is essential for improving the outcomes of these interactions, such as reducing client distress.

Consequently, examining the experiences and perspectives of empathy recipients offers a more comprehensive and nuanced understanding of how these interactions unfold. This approach also underscores potential areas where service providers and organizations should focus on enabling employees to respond with the appropriate empathetic behaviours when interacting with clients.

Second, the findings of this research underscore the pivotal role of nonverbal behaviours in communication, particularly in the context of empathy in intercultural communication. While verbal communication is undoubtedly essential, nonverbal cues such as facial expressions, gestures, vocal tone, and body language often convey nuanced emotional information that can significantly impact the effectiveness of empathic communication, particularly for high-context cultures. By giving prominence to nonverbal behaviours in evaluating empathy within intercultural contexts, this study highlights their significance and potential to shape recipients' emotional experiences. This study has demonstrated that Arab newcomer patients' assessment of the empathic quality of their intercultural interactions with their non-Arab healthcare providers in Canada is not uniformly positive. It also demonstrated that the empathic nonverbal behaviours

expected by culturally different recipients have consequences. For example, it highlights how nonverbal cues such as facial expressions, tone of voice, and body language are interpreted differently. This, too, moves beyond gap-filling and sheds new light on prior theory findings and related assumptions. To illustrate how these findings are insightful, consider the study by Derksen et al. (2017), in which 28 patients from four different regions in the Netherlands engaged in focus group interviews to discuss the role of empathy in their interactions with physicians. The results of that study revealed that patients recognized the significance of empathy, noting that it contributed to the development of more personal and welcoming provider-patient relationships. They described empathy in terms of three key components: the provider's attitude (including receptiveness, commitment, and authenticity), competencies (such as being taken seriously, feeling welcome, and being actively listened to), and observable behaviours (resulting in feelings of safety, trust, and support).

However, that study's findings could have been further enriched by delving into how and why empathy was either experienced or lacking in these interactions. While the scholars were attentive to factors like gender, age, and education levels of patients and providers, the study did not consider the cultural backgrounds of these individuals. Failure to consider cultural differences between the providers and their patients may have led to misinterpretations of the patients' assessments of empathy. As Morgan and Nickson (2001) noted, such cultural differences can indeed lead to misunderstandings. Conversely, the findings of my study underscore the impact of cultural differences in the use and interpretation of nonverbal behaviours, such as the distinction between high-context and low-context communication (as discussed by Hall (McKay-Semmler, 2017)), the influence of time management during consultations, and the role of body language (as suggested by Bonaccio et al., 2016). These

cultural variations may likewise have significantly shaped how patients evaluated their healthcare providers in the study within the Dutch healthcare setting (Derksen et al. (2017).

Third, given both above, the detailed descriptions of diverse verbal and nonverbal behaviours that influence cultural interpretations of empathy validate and expand the conceptual model of communicated empathy deducted in the conceptual model presented at the start of this paper. They clearly illustrate that what recipients perceive as empathic or non-empathic in a specific context may vary by population. These specific examples contribute not only to the empathic communication literature but also to the cross-cultural literature by underscoring the significant role of empathy in bridging cultural gaps and improving communication, even in a context where individuals lack in-depth cultural knowledge or competence. The experiences shared by Arab newcomer recipients illustrate how empathy can potentially transcend cultural barriers and positively influence intercultural interactions. Theoretically, this represents a *novel* contribution to the cross-cultural literature. From a practical perspective, this study's findings are particularly relevant in today's globalized world, where individuals frequently find themselves in unfamiliar cultural contexts, and empathy may prove to be a valuable, *actionable* tool for international managers and practitioners seeking to enhance intercultural communication and cooperation.

Furthermore, the study introduces novel factors, such as recipients' proactive interventions and systemic challenges, which have not been extensively explored at all in existing empathic or cross-cultural communication studies. These system-related additions to the conceptual model enhance its comprehensiveness and reveal new barriers and opportunities. Systemic barriers can include hindering communication and obstacles to accessing quality healthcare services. Patients who experience poorly communicated empathy in the context of

these systemic barriers may regard the healthcare system as one that lacks empathy and consideration for their needs, ultimately influencing their overall appraisal of the system. Conversely, recipients' proactive behavioural interventions can be dynamic and influential in shaping empathic interactions. They empower individuals to assert their needs, preferences, and emotions, fostering more effective and empathic communication and actions from empathy senders. Proactive participation can thus lead to more tailored and responsive empathic behaviours, ultimately improving the quality of interactions and the perception of empathy in various contexts, including healthcare and intercultural communication.

In essence, this study pioneers a novel and actionable perspective by not only focusing on the individual level of analysis (i.e., empathy perceived by recipients) but also recognizing the intricate interplay between these individual-level verbal and nonverbal dynamics and more systemic-level contextual factors in the communication of empathy.

Practical Implications

Multiple practical implications emerge from this study. Below, implications are specified for the recipients/patients, the healthcare providers, the healthcare system, and the recipient/patients' cultural community.

First, this study's findings demonstrate the recipients' role in communication. Their feedback is essential to teaching the senders how to adjust their verbal and nonverbal behaviours to improve the recipients' experiences. Hence, recipients are encouraged to voice their opinions and concerns. Newcomer recipients, in particular, should be active and engaged in intercultural interactions and refrain from developing learned helplessness (Martinko & Gardner, 1982), where they would become inactive and continue to be so in their intercultural interactions, even when the provider may become more responsive. This assertive approach potentially leads to

better behavioural and health outcomes. However, one potential constraint would be that Middle Eastern cultures have relatively high expectations of power distance (Hofstede, 2001). This means that these cultures tend to show respect for authority and have a more formal communication style with people in higher positions (e.g., health care providers), which may limit their assertiveness.

For the senders (healthcare providers) experiencing (or about to engage in) intercultural interactions, senders should appreciate their influence on their recipients' physical and mental health and their role in reducing uncertainty. Accordingly, they should consider the study's findings when interacting with cultural minorities and new societal members, proactively seeking cues for empathy from their recipients and using the underscored behaviours in their consults.

Organizational leaders, including human resource personnel, need to make more efforts to make the healthcare system diverse and inclusive. Suggested interventions include increasing cultural representation among sender-providers, educating senders through empathy-building and empathy-enhancing training interventions in different organizational contexts to motivate the pertinence of empathy to specific organizational roles and alerting organizational members to the need to be attentive to diverse verbal and nonverbal cultural empathic cues (where nonverbal behaviours could overcome the language and cultural barriers). Toward this end, they might consider including newcomer recipients in designing these training interventions during the planning stage and providing medically relevant translation and interpretation services.

Equally important, given this study's findings, is the need to provide orientation to newcomers entering the Canadian healthcare system. This orientation should encompass educating them about their rights and emphasizing the significance of their voices in their treatment. This suggestion also has the potential to help newcomers establish realistic and

achievable expectations. They can develop more realistic expectations regarding the healthcare services they can access and the potential obstacles they may face. Realistic expectations can reduce the likelihood of disappointment and frustration when they encounter these challenges. For example, when newcomers realize that some of the obstacles and systemic issues they encounter are not unique to them but affect the broader population, it can lead to a sense of fairness, aligning with the principles of equity theory (it suggests that individuals assess the fairness of their situations by comparing them to the situations of others (Adams, 1965)). This, in turn, can contribute to a more positive perception of the Canadian healthcare system, even in the face of its flaws.

Recommendations for the Middle Eastern immigrant community include actively advocating for the needs of its community members to healthcare providers. Specifically, educating providers about cultural norms and values pertinent to healthcare contexts, and more specifically, the newcomer patient's expectations regarding verbal and nonverbal behaviours in a healthcare context. In addition, arrangements could be made to provide Halal meals to patients who ask for them and clothes extensions (e.g., sleeve extensions, neck covers) to enable its newcomers to adapt and navigate the healthcare system. Professional language assistance could also be provided by enabling systemic access to medical interpretation services for newcomers – mainly using culturally competent translators or with a common grounding with the patients. Finally, newcomers may also benefit from education about cultural differences, healthcare practices (to develop their health literacy), their rights and responsibilities, and available resources (e.g., social services and mental health services) to compensate for any lack of healthcare orientation offered by the health system.

Limitations of The Study

No study is without limitations, and several should be noted here as well. First, concerning the sample, the focus was on newcomer immigrants and refugees with common characteristics (i.e., minority culture individuals within vulnerable healthcare situations, not healthy newcomers who hail from the dominant cultural groups of the society). Relatedly, no data was collected on the participants' socioeconomic status; Hence, a deeper understanding of the underlying reasons for their choices was limited (e.g., poorer newcomers may be constrained to local providers due to lack of a vehicle or inconvenient public transit). Future research may overcome these limitations by examining the socioeconomic categories of expatriate newcomers and newcomers in different intercultural communication settings (e.g., which require empathic service interactions, albeit not in healthcare) and interviewing a more diverse sample with a broader range of demographic differences, to explore whether such differences may influence decisions and subjective appraisals.

A second concerns the measurement tools. Cultural values were not measured explicitly. However, this limitation was mitigated by the decision to interview *only* Arabic-speaking newcomers regarding their interactions with sender-providers from a Western culture. These regional variations acted as proxies for two cultures with salient cultural differences. Future studies may opt to measure cultural value dimensions more directly (e.g., Hofstede's).

Third, concerning data collection, data was collected in Ottawa, Ontario, using purposive and snowballing techniques, limiting its generalizability to other geographical places with potentially different contextual (re: healthcare system or other) influences. Future research may select other contexts where intercultural communication with newcomer recipients from a Middle Eastern background is significant to explore whether the cultural observations from this study could be transferable elsewhere. However, the high-level conclusions, particularly the

culturally relevant observations from this study, could be relevant and transferable to other contexts where intercultural communications with newcomer recipients from a Middle Eastern background are significant.

In addition, the interview recordings' translations were not subject to reverse translations from a second expert in Arabic due to budget constraints. With a larger budget, future research on these issues could conduct reverse translations. Second, recipient participants were not matched with sender participants, and the data was retrospective. This shortcoming makes it difficult to interpret any unforeseen confounds that may have arisen in situ between enacted and communicated (i.e., perceived) empathy.

Furthermore, because the focus of data collection in this study was on patients who interact with community healthcare centers (which involve more extended continuity of care and longer-term consultant relationships), no data were collected regarding their first impressions and related interpretations in walk-in healthcare delivery clinics. Yet, first impressions formed during these brief encounters can potentially also impact how patients perceive the quality of care and the healthcare provider. In acknowledgement of this, future research may benefit from studying interactions in walk-in clinics to identify communication barriers or issues that may also need addressing within this context.

Interviews were conducted over the phone due to confidentiality concerns and the restrictions imposed by the Covid-19 pandemic. This hindered the opportunity to observe firsthand interactions and record the myriad of nonverbal behaviours occurring. Also, due to confidentiality and privacy concerns, the participants' senders-providers were not identified and interviewed to establish a paired/matched view of the empathic interaction.

Fourth, member-checking was constrained prior to thesis submission due to time constraints. Although the researcher obtained some respondents' immediate validation during the data collection process (paraphrasing or summarizing what the participant had said to confirm her understanding of the participant's intended meaning), this was not done systematically. To remedy this oversight, before journal publication, the researcher will compile and disseminate a summary of the findings (in the form of themes that have emerged from the data) and subsequently review these findings with willing participants to confirm whether the summarized findings accurately represent their experiences. Any needed corrections will be noted in further iterations of this manuscript.

Future Research Directions

Despite the above limitations, this study offers a fruitful starting point for exploring the perspectives of newcomers as recipients in intercultural interactions. Going forward, investigating the perspectives of culturally different groups (i.e., with different ranges of culture distance) of recipients is recommended, particularly with qualitative empirical studies in different contexts where empathy is required/expected in the interactional situation, as the resultant detailed descriptions of culturally appropriate demonstrations of communicated empathy (verbally and nonverbally) may help to provide global validity of the model. This model might also be applied to study the communication of empathy in contexts with a need for considerable conflict and negotiation management (Adair & Brett, 2004; Cikara et al., 2011), particularly when conflicting/negotiating parties have different cultural/religious assumptions and goals for the communication process.

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Appendix

Table 1. *Participants' Demographics*

Partici-pants	***Nature of Shared Experiences (1=Negative, 2=Mixed, 3=Positive)***	***Country of Origin***	***Years In Canada***	***No. of Spoken Languages***	***Interpreter (1=Yes, 0=No)***	***Education***	***Gender***	***Choice of Provider (0=Assigned, 1=Self-selected)***	***Previous Experience with Foreigners (1=Yes, 0=No)***	***Behavioural CQ Score***	***Behavioural CQ Category***
1	2	Yaman	3	1	1	Primary	F	1 (Speaks Arabic)	0	19	Medium
2	2	Syria	5	2	1	Primary	F	1 (Speaks Arabic)	0	21	High
3	1	Tunis	3	3	0	BSc	M	1 (community recommendation)	1	17	Medium
4	1	Syria	2	1	1	Primary	F	1 (Speaks Arabic)	0	16	Medium
5	2	Syria	2	1	1	Diploma	M	1 (Speaks Arabic)	0	11	Low
6	2	Syria	2	1	1	Diploma	M	0	0	19	Medium
7	2	Syria	5	2	0	Diploma	F	1 (community recommendation)	1	25	High
8	2	KSA	5	2	0	BSc	F	1 (proximity/accessibility)	1	5	Low
9	Avoided mentioning specific incidents	Egypt	5	4	0	MSc	F	1 (proximity/accessibility)	1	17	Medium

10	2	Egypt	4	3	0	MSc	F	1 (community recommendation)	1	14	Medium
11	2	Egypt	4	3	0	Bsc	F	0	1	7	Low
12	2	Syria	5	1	1	High School	F	1 (Speaks Arabic)	1	7	Low
13	2	Egypt	5	2	0	BSc	F	1 (proximity/accessibility)	1	12	Low
14	1	Egypt	5	2	0	BSc	F	1 (community recommendation)	0	5	Low
15	2	Egypt	2	2	0	Ph.D.	F	1 (proximity/accessibility)	1	20	High
16	Avoided mentioning specific incidents	Syria	5	1	1	BSc	F	1 (Speaks Arabic)	0	14	Medium
17	1	Syria	5	2	0	BSc	F	1 (Speaks Arabic)	1	11	Low
18	1	Syria	5	2	0	BSc	F	1 (proximity/accessibility)	1	22	High
19	1	Syria	3	1	1	Primary	F	1 (community recommendation)	0	5	Low
20	2	Egypt	5	2	0	MSc	M	1 (proximity/accessibility)	1	12	Low
21	2	Egypt	5	2	1	MSc	F	1 (community recommendation)	1	18	Medium
22	2	Egypt	5	4	0	MSc	F	0	1	19	Medium
23	2	Egypt	4	2	0	MSc	F	1 (proximity/accessibility)	1	17	Medium

24	2	Kuwait	5	2	0	MSc	M	1 (proximity/accessibility)	1	17	Medium
25	1	Egypt	5	3	0	Ph.D.	M	1 (proximity/accessibility)	1	14	Medium
26	2	Egypt	5	2	1	Ph.D.	M	1 (proximity/accessibility)	1	14	Medium
27	2	Egypt	4	2	0	MSc	M	1 (community recommendation)	0	21	High
28	2	Syria	5	2	0	BSc	M	1 (proximity/accessibility)	1	17	Medium
29	1	Palestine	2	2	0	MSc	F	0	1	19	Medium
30	2	Egypt	3	3	0	BSc	F	1 (proximity/accessibility)	1	16	Medium

Table 2. *Interview Protocol*

Topics	Interview Questions and Probes
Context	What can you tell me about yourself. a. When did you move to Canada? b. How do you find life here? c. Do you have frequent encounters with service providers from a Western/Westernized background? Why do you interact with them regularly? d. What aspects the interaction that you like? Other aspects you do not enjoy? Why both?
Positive example	Can you think of any interactional example where you were satisfied/happy with the exchange between you and the service provider? a. Why did this example resonate with you? b. How did the service provider act? Describe their behaviour? c. What kind of verbal and nonverbal signals did they use? d. Why do you think the service employee acted this way? e. How did you respond? Why? f. Did these exchanges cause you to behave differently afterwards?
Negative example	Can you think of any interactional examples that were negative? a. What happened during these exchanges? b. How did the service provider act? c. How did you respond? Why? d. Why do you consider these exchanges were unpleasant? e. Have you done anything to avoid the reasons for these unpleasant exchanges? f. How did these encounters influence your behaviour afterwards?
Concluding remarks	1. What do you remind yourself of when you interact with persons from a culture different than yours? 2. What would you tell persons from other cultures to be mindful of when they interact with a newcomer, such as yourself? 3. Can you think of other important things about cross-cultural interactions for newcomers and I haven't asked you about? 4. Are there other examples you'd like to share? 5. Can you think of people in your social network who could talk to me and would be willing to? Would you forward my recruitment message to them?

Table 3. *Illustrative Quotations for Second-Order Themeson Senders' Offering Help Behaviours*

Second-order Theme	Quotation	
	Positive Examples	Negative Examples
Sender giving sufficient time during the consult	• "Even though I did not master the local language, they (the providers) were still helpful and compassionate… I take more time trying to explain my condition to the provider… There are some of them who do that (allow enough time to listen and explain)." (RIMM1) • "I really appreciate it when the provider is being friendly and trying to explain what is happening. Like, in some cases, the healthcare provider is super friendly, and they take their time to explain, you know, like "you have this because it is normal, or you are exhausted, or because..."." (RIMM10) • "What makes me more comfortable is always when the provider takes the time to explain to me exactly what I have and how I are going to treat it. So, basically when they take the time to explain." (RIMM11) • "One provider gave me my whole time and I could stay there more than one hour if I wanted, and no one hastened me." (RIMM13)	• "They are very tight in time, they do not, they do not listen to you well, or you feel like you are not being cared for properly, because you are not being listened to." (RIMM8) • "I always feel they are in a rush and do not have time for me to talk about what I am feeling; they always give the feeling of "I do not have time for you." (RIMM14) • "It is like hurry up, hurry up! (laughs) They just want to end the visit and say goodbye!" (RIMM18) • "Yes, he (the provider) rushes. I feel like I am in a hurry to say everything because I am afraid to forget any point because I know that I will only meet him again after a month." (RIMM22)
Sender responding to questions	• "I like just the fact that someone is available at like, all times or most of the time answering questions and to guide you if you need to be guided in a certain way. And at	"I always had some concerns and questions that they (providers) did not answer about the symptoms I had… She gave me brief answers… She used to answer me exactly as

	the same time relaying that information to the specialist." (RIMM8) • "She (the provider) answers all the questions, offers all the information…" (RIMM13) • "You (participant talking about themselves in the third person) can question anything; they (the providers) do not complain." (RIMM16)	much as I asked, and she never tried to give me details about my condition." (RIMM18)
Sender proactively sharing information	• "They (the providers) always tell me if they do not call me, then my bloodwork is okay. But, this provider took the time, and she sent me a message that most of my blood work is okay, except I need to take some vitamins like vitamin D and stuff like that. And she was very fast, like, the next day of my results she texted me, so I appreciated that she took the time to go out of her way and do that." (RIMM10) • I think the patient, like me (with a Middle Eastern background), prefers to know more and to hear an explanation about their status. For example, when I went to take Covid-19 vaccine, the nurse gave me a long introduction about the pain I will feel after taking the vaccine." (RIMM17) • "She (the provider) called me on Canada day and explained the situation and the risks. I told her about my travel plans, and she said I could not do that. Then she told me about the medication and started to search for the open pharmacies during Canada Day to send me the prescription. Also, she gave me her	• "Some providers were a bit like, kind of reluctant to provide you with extra information. For example, if you did not ask for it. They do not always provide you with extra information, like you have to ask for everything." (RIMM8) • "The provider's attitude is if I did not ask or do my research before the appointment to find the right questions to ask, they do not offer the information." (RIMM13) • They do not tell you enough about your condition to make you feel better… I have the opposite way in my countries (the Middle East). The providers [from there] give you the facts from when you were a child until the day you visited them explaining why something happened to you. They make you understand everything in a way that makes you comfortable." (RIMM18)

	personal number because it was Canada Day, and she knew I could not reach anyone. She exceeded expectations." (RIMM21)	
Sender validating recipient's concerns	• "They (the providers) were sensitive about how to reveal a diagnosis… And then how to support like how to support me after the diagnosis. Like they really showed me like the resources on who to talk to and where to read stuff about the condition." (RIMM8) • "If I want a referral, suspect that there is something, need a test or anything else, thankfully my family doctor has a good attitude so if I need to do something, I do it. It feels good to know that he will not ignore me if there is a possibility of something suspicious." (RIMM13)	• "Nobody was compassionate about my concerns… Literally I was told this: "Well, you have to deal with the pain! There is nothing I can do."" (RIMM3) • "She (the provider) did not even try to explain anything, or, you know, maybe if she dug a bit more, she would find something... And she was like ignoring how I feel just because I look healthy, because you can always look healthy, but you might have an underlying problem or something… she even told me "If you do not like me, leave"… I come from a culture where I go to the Doctor, and the Doctor usually either prescribes medicine or refers you to someone or like, you know, tries to explain to you what is going on. What is frustrating here, at least with this family doctor team that I have seen is that everything is normal." (RIMM10)
Sender accommodating recipient's language/linguistic constraints	• "They (the provider) asked about my native language and then they sent me an Arabic version of the correspondence and informational resources I needed or was supposed to receive. They provided an Arabic copy for those who do not know English or it is not their mother language.	• "When I first arrived here, there was great difficulty concerning my interactions with the providers. It was mostly a language barrier… They (the provider's office) would call me and inquire about the reason (for not coming to the appointment) and I would have some difficulty communicating with

	They accommodated this cultural difference." (RIMM15) • "So, the family doctor was Canadian (from a Western background), and the nurse was Egyptian. They used to bring her (the nurse) during my appointments… They wanted to ensure that I understood everything they said and to help us explain my status. I was not able to translate and present, especially the medical terms… Sometimes they said some medical expressions, asked about specific things in the medical history or a previous illness I got, so it was easier for them to ask for help from the Egyptian nurse to explain any medical condition." (RIMM26)	them... Yes (language was the only barrier). They usually leave me a voice mail in English for me to get back to them and when I cannot do that, they would send me another voice mail asking me to call them back and by then, my appointment is overdue." (RIMM2) • "Honestly, and depending on my and others' experiences, the way Western providers interact with you will differ according to your English language proficiency. They will treat you better the more you are fluent… Throughout the time I realized that they would treat me differently if I could speak English well. I notice this and I suffer from it… I notice that things are different when you talk in English… I wish they (the provider" can provide us with a translator because I suffer from the language barrier so much… Here if you cannot talk in English, you are nothing!" (RIMM4) • "When I did not understand a medical term, she (the provider) made me feel stupid for not knowing it and did not help in explaining it..." (RIMM11)

Table 4. *Illustrative Quotations for Second-Order Themes on Cultural Awareness Displays*

Second-order Theme	Quotation
On uncertainty avoidance	• "They (providers) are always scared to give a definite diagnosis. I do not know if something is wrong; nobody gave me a definite… nobody was compassionate about my concerns…" (RIMM3) • "My problem is with the specialist who does not give me a clear idea or enough explanation about what I am going through. I usually need to understand more… In my country, you visit a provider, and he gives you a clinical examination and asks you about what you feel, and I think that is very comforting for us as Arabs... Also, I think the patient, like me (with a Middle Eastern background), prefers to know more and to hear an explanation about their status." (RIMM17) • "They are constantly guessing by using statements like "I think you are suffering from something…", and "I think you need something…". You (the provider) are the one who should know!" (RIMM18) • "I liked that he (the provider) was decisive. If I had to take a specific medicine, he asked us to take it. He always has a plan, unlike the other doctors who ask us to decide what to do! You are the Doctor who must tell me what to do." (RIMM26)*
Neutral/task-oriented choice of words	• "It (the interaction) was quite pragmatic rather than humane... Canadian nurses and doctors are hard to talk to, especially since they are mostly serious and not into side talks." (RIMM1) • "They (the providers) were very cold [in their conversations]." (RIMM18)
On collectivism	"Family is really important to us. And I usually have some family accompanying us in my visits, medication appointments, or whatever it is… Also show the support person like care and respect… Maybe even, like, give them a heads up on what is happening or whatever it is like. But that individual (support person/family member) is usually also like, you know, dismissed in a way or just sits in the waiting room or whatever. They (the providers) do not acknowledge the family member most of the time, and they speak directly to the patient, which I understand because there is patient confidentiality and all of that, so it is like a fine line." (RIMM8)
On time	"The provider called us up and asked us to come, and she was quite angry with us when I arrived because I did not make it on time. Another provider calmed her down and asked us to reschedule. That day, I was frustrated and wished I would return to Turkey!" (RIMM1)

On particularism	• "Please try to talk to the social affairs employee at (name of the hospital) on my behalf (participant asking the interviewer for special help); people in the community told me he could help me with this (participant's situation) and provide allowances, transportation and disability services. As I told you, I came two years ago, but I know nothing." (RIMM5) • "To be honest, no (the participant did not communicate with the hospital). I hope I can find someone to contact them for me, but there is no one." (RIMM19)

*An example of a positive experience.

Table 5. *Illustrative Quotations for Second-Order Themes on Systemic Healthcare Barriers*

Second-order Theme	Quotation
Lack of orientation to the healthcare system	• Here [in Canada], we are totally lost; we do not know where to go to receive specific healthcare services. We came to Canada two years ago, but still, we know nothing (RIMM5). • My big problem is that when I moved to Canada as a newcomer, I did not know how to navigate the healthcare system. Knowing whom to go to and for what takes me a very long time. How to go about things, and how to access the information? Maybe because I did not grow up here, I do not know how. I feel I must work extra on it so I can find information whenever I need something. I also do not know how to find it by myself easily. There are many great available services, but no one speaks about them or is unclear. I think it is important to make the information more accessible or to make newcomers at least know what is available for them in the healthcare system and how to navigate it (RIMM13). • They [providers] need to understand that we are not used to going to a family doctor and having a mediator to then see any specialialist. At home, we go to the specialist right away… They need to understand the different cultures and that we do not know the system here (RIMM10). • Here, how they [providers] work, or their work approach is different than back home. I had to get used to it by myself… Providers should know that how doctors deal with patients or their approach might be different in every country, so they must make sure that the patient understands them (RIMM11). • I was not prepared at all [to deal with the healthcare system] (RIMM23).
Emphasis on protocol compliance	• "They [the provider] do not allow the translator to enter the room with me [Covid-19 restrictions]. My English language is still weak. I need a translator to be with me whenever I get to the hospital, so I can understand my status well and tell what I feel accurately. How will they understand me? This is another problem we already suffer from [emphasis on following rules]." (RIMM4) • "The provider asked me: "Do you have abdominal pain?" I told her "No, but I'm having a baby, so, I have contractions. She was like: "Oh, so you do have abdominal pain!" and I was like: "No, I am giving birth. You need to listen to what I am saying. I am in my ninth month. This is the day I am giving birth." But she said "No, you have

	Covid-19 [because abdominal pain was a symptom of Covid-19]" And then she took me to a separate room and treated me as if I had Covid-19." (RIMM10) • "I wanted to say that they [the providers in general] do not pay enough attention as they should until the medical problem gets very dangerous. I do not know if it is related to their culture, but they think that feeling pain is not enough to take action or react unless you are suffering from a critical issue then, they may take it seriously and consider it urgently. So, the process is terribly slow." (RIMM17) "They [the provider] follow a specific procedure and will not change it to suit you." (RIMM26)
Booking delays with specialists	• "I may need to see an ENT doctor and it may take me 3-4 months to reserve an appointment which causes issues for me." (RIMM1) • "There is always difficulty in reserving appointments with specialists." (RIMM2) • "It's so hard to find a quick appointment when you need to go to a specialist. It might take months." (RIMM11) • "You may get ill and recover while you are still waiting for your appointment." (RIMM12)
Low General Practitioner accessibility	• "The physician:patient ratio was low. They are impossible to reach, it is very hard to reach them, or it takes ages for them to get back to you if you leave a message with the nurse or with whoever is working with the provider. And then if they do, a lot of times, they are very tight on time" (RIMM8) • "I thought about leaving my family doctor, but she even told me like, "if you do not like me, leave" because she knows I am not going to find anyone else. So, we need more nice doctors." (RIMM10) • "I think the system needs more doctors in every field." (RIMM11) • "He [the receptionist] told me that there was just one doctor there. There were like 100 patients for one doctor!" (RIMM18)
Delayed feedback from consults or No follow up on patient later	• "The doctor did not know what was wrong, so she referred me to another person, and the other person referred me to another person, so I ended up from October 2019 until December 2020, which is a year and two months, I had more than 5 MRIs and I've seen 4 specialists, but they did not reach a resolution or a definite diagnosis… Everyone pushes it to the other." (RIMM3) • Sometimes, they ask us to do some tests, and it takes ages to get the results… He [the provider] did not say that he needs to see him [RIMM18's son, who is the patient]

	later to ensure everything was ok. After all, it was surgery. He did not follow up on his case… He should have asked me to bring my son to check on him." (RIMM18) • "They [the providers] have not contacted us for three years [to schedule a surgery], and we do not know why." (RIMM19) • "They [the providers in general] do not give you immediate feedback." (RIMM21)
Self-reliance expectations in communication	• "I would love for them [the providers] to help us with the interpretation, given that I do not understand the language properly. The other thing is the facilitation of appointment reservations. I miss appointments because I do not speak the language well, are old, and are unfamiliar with technology... Yes, that is important [having someone who speaks Arabic at the centre]." (RIMM1) • "When I first came here, there was great difficulty concerning my interactions with the providers, and it was mostly a language barrier… I desperately needed an interpreter because I did not understand what the doctors and nurses said. But they were not able to provide that. I had to ask my 14-year-old son to come to the hospital to help interpret some things, and he still could not communicate the picture entirely. That said, I would want them to provide translators." (RIMM2) • "I realized that they [providers] would treat you differently if you could speak English well… They will treat you better the more you are fluent." (RIMM4)
Long waiting time in clinic	• "It was such a long process. You first head to the reception and wait for 3-4 hours for a vacant bed and then wait another 4-5 hours for the doctor in charge to see you. I have encountered this a lot." (RIMM1) • "I had to wait more than 8 hours to get in." (RIMM3) • "The first time we went to make a registration, it took 4 hours to see a provider." (RIMM26)
Overlooking different cultural norms	• "The hospital gowns were so revealing, even though the doctors had long-sleeved clothes. I asked for that [less revealing, long-sleeved gown] in the hospital, and they [the provider] told me there was no such thing." (RIMM22)
Insufficient diversity among providers	• "I hope the system hires more providers with different backgrounds. I believe that if they do this, they will be accommodating everyone." (RIMM28)

Table 6. *Illustrative Quotations for Second-Order Themes on The Recipient's Self-Advocacy during The Consultation*

Second-order Theme	Quotation
Demonstrating initiative to obtain verbal accommodations in the absence of language capacity/accommodations	1. On bringing-in translational resources: "I also use the translator on my phone to communicate with the provider what I want to say." (RIMM1) 2. On Learning English: "I take English lessons, and my language is improving recently. I try to practice in my appointments." (RIMM4) 3. Using nonverbal behaviours: • "Sometimes I use some words and other times I use body language… I try to understand how they [providers] look at me or use their hands. I then shake my head to answer with yes or no." (RIMM14) • "I always use it (nonverbal language). If the person I talk with is a Canadian or a foreigner, 60% of the speech I do not get. I must focus on them and be face-to-face. I have lived here for 5 years, so I know I must make eye contact. I need to see their faces and watch what they are saying so I can get what they want from me... I must pay attention to the lips and hand movement." (RIMM16) • "I can express myself more easily face-to-face... I use my hands sometimes to explain or point at the pain or show the providers something I cannot express in words, and mostly it works." (RIMM17)
Confronting dismissive sender	• "I politely told him [the provider]: "You do not talk to someone like this [in a dismissive way]. This is my problem. This is my burden, and I feel it is the heaviest burden even if all the people have it, I am talking about myself now, it is my time. I booked an appointment and waited for you for 3 months not to hear you telling me this [provider responding with "We all have back pain."]. This is not a therapy session, so you can tell me everyone is dealing with this pain." (RIMM3) • "I tried to tell her [the provider], I said "I'm pregnant, I have this issue. And you know, my gynecologist told me to reach out to you. And I feel like you are being dismissive of my problem."; like I also even sent a full text to her so that she understands me and does not claim I said or did something else." (RIMM10)

Sharing cultural/spiritual information with the sender to educate them about the recipient's cultural practices	• "They [the providers] might ask me about my religion, about things they do not understand or know. I answer as much as possible, and if I cannot because I do not know the answer, I search. With that, they could understand and change their perspective." (RIMM9) • "I explained to them [providers at the hospital] that Kosher food was okay, as it is considered the closest to Halal food." (RIMM15)

Figure 1. *Model of Communicated Empathy from Hussein & O'Sullivan (2020)*

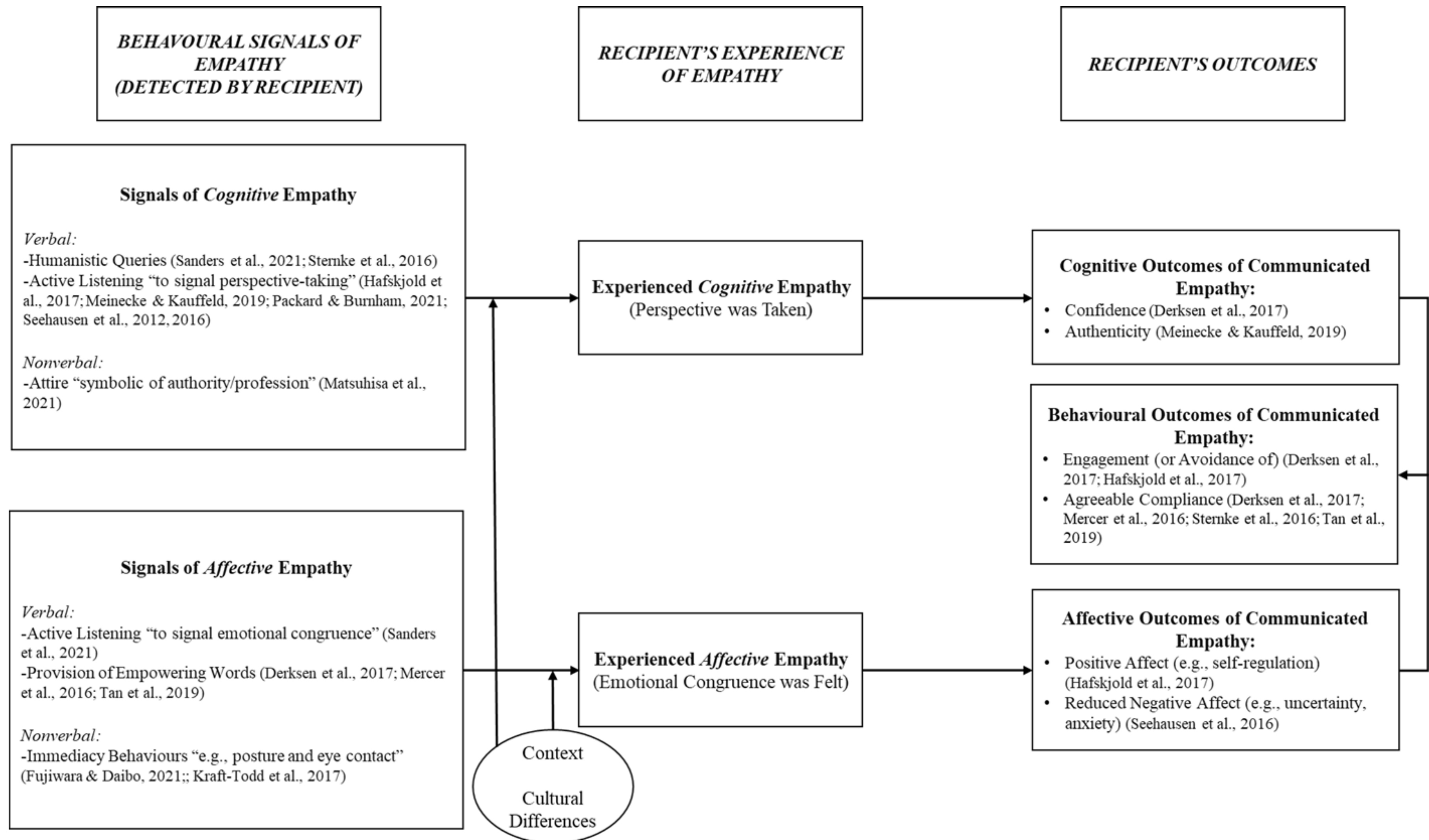


Figure 2. *Data Structure*

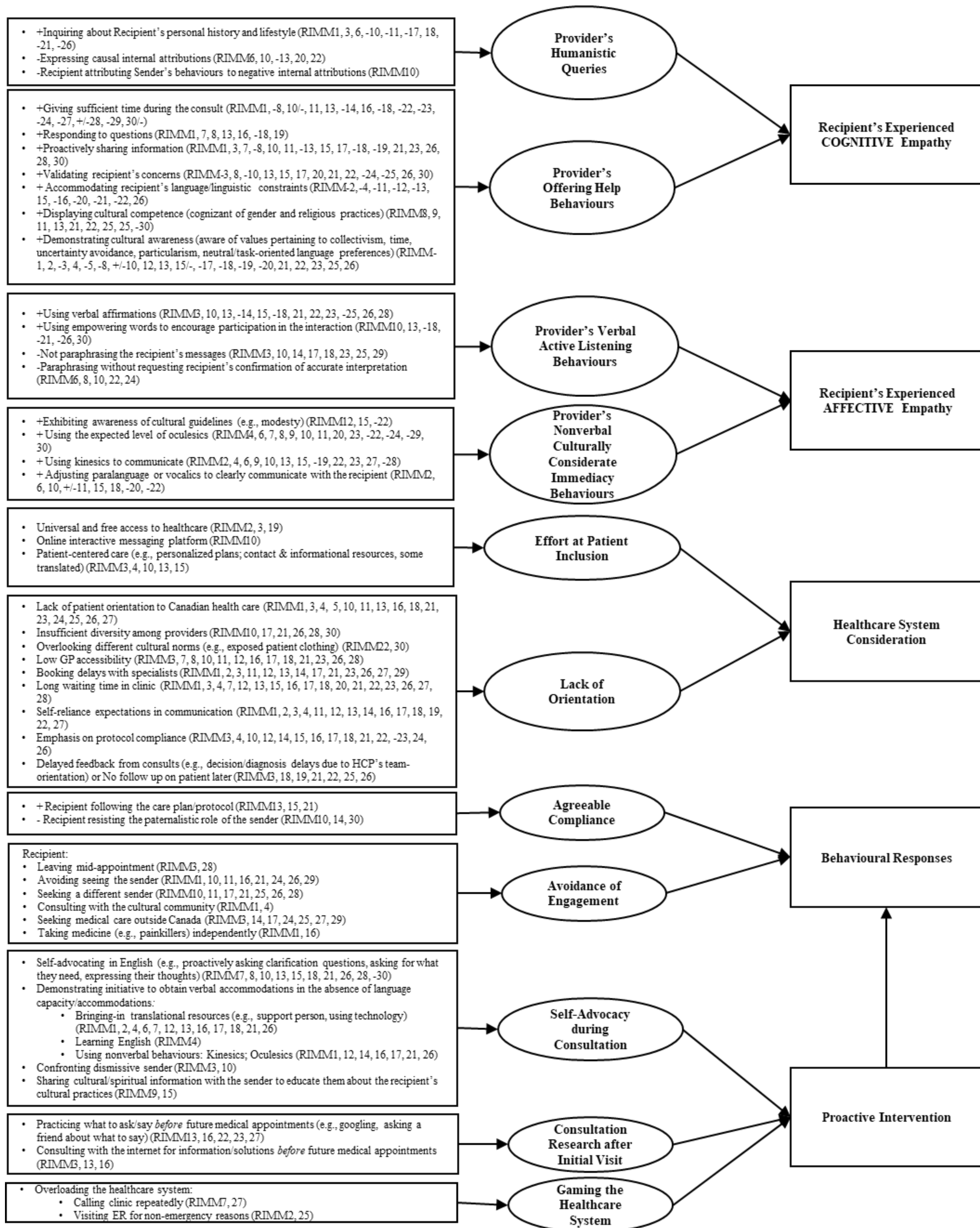
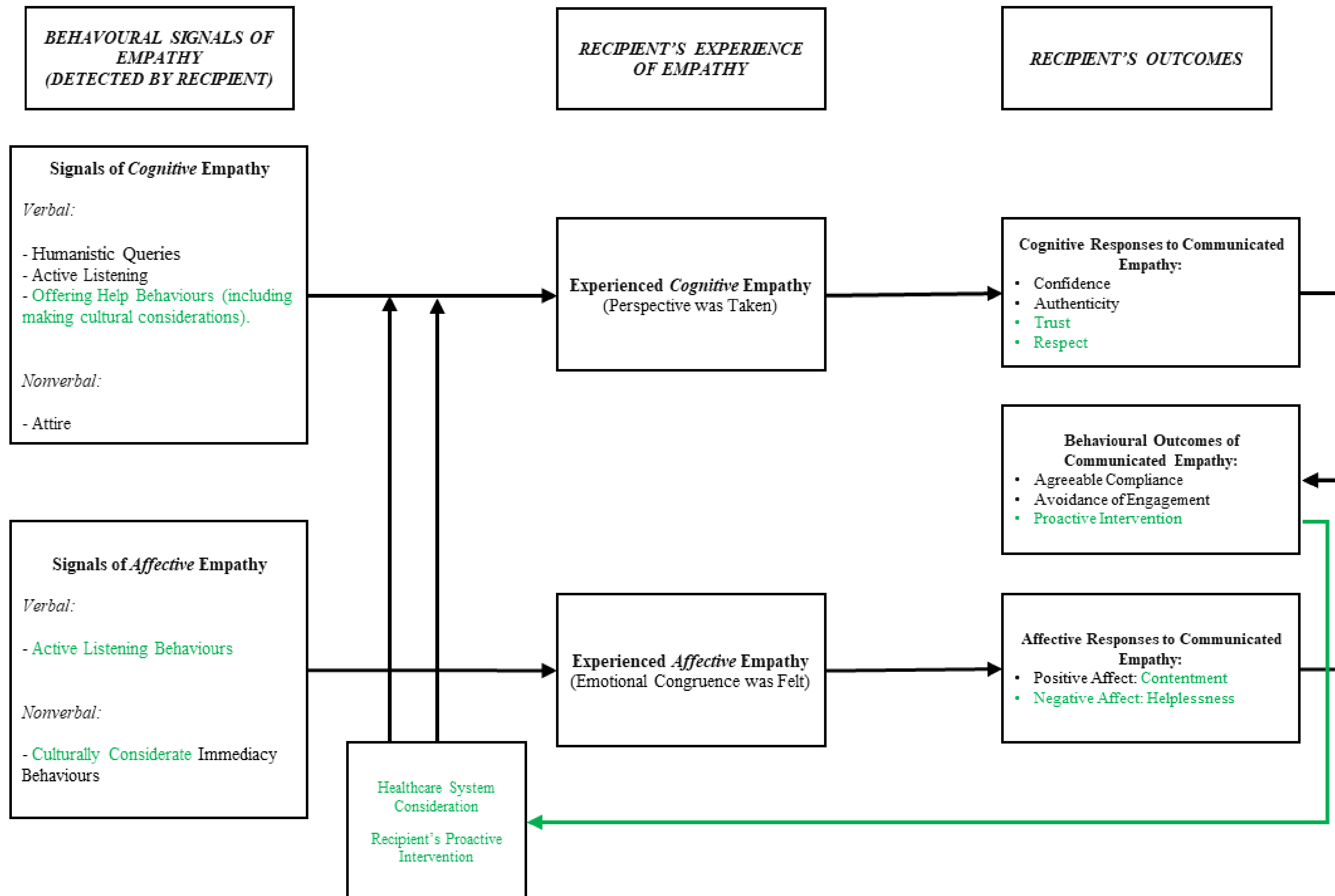


Figure 3. Revised Model of Communicated Empathy



Items in green are new additions to the literature based on the data

Empathic Intercultural Communication by Healthcare Providers: Understanding and Addressing Middle Eastern Immigrant Patients' Needs in Canada

Abstract

Globalization has revolutionized how people live and work, facilitating intercultural connections and communication. However, the intercultural nature of such interactions presents challenges for communications. Although empathy has emerged as a potential element in resolving miscommunications in general, empirical research is lacking regarding empathy's role in contributing specifically to positive interactions in diverse communication contexts, such as *intercultural* service provision.

This study bridges this research gap by examining the experiences and perspectives of Western/Westernized healthcare providers on the empathic communication process and its implications in intercultural interactions with Middle Eastern newcomer patients in Ontario, Canada. Twenty-six semi-structured interviews were conducted with healthcare providers. Data was analyzed with an inductive approach. Results demonstrate that providers understand empathy and are aware of the behaviours that can demonstrate empathy. These empathic behaviours were categorized into three main categories: Attentive perspective-taking, caring active listening, and accommodating/empowering patients. Providers enacted these behaviours by inquiring about traditions and lived experiences, conveying care using specific verbal and nonverbal behaviours, including humour –typical within the Middle Eastern culture, and by providing feasible accommodations and educating patients to enhance their agency. In the providers' view, these efforts at effective empathic communication led to positive outcomes for themselves and their patients. These insights advance theoretical understanding of intercultural

communication and provide practical guidelines for individuals and organizations wishing to promote positive and productive intercultural experiences to address the challenges posed by globalization in today's interconnected world.

Introduction

Globalization has transformed people's lives and work, enabling individuals to connect and communicate across geographical boundaries (Maddux et al., 2021). While this interconnectedness offers numerous benefits, it has also given rise to potential challenges in intercultural interactions. Thus, empirical research is needed to identify the key factors contributing to positive intercultural experiences (Lamancuso et al., 2016) to ensure high-quality interactions and minimize miscommunications.

Empathy has emerged as a critical potential element in facilitating effective communication (Clark et al., 2019; Lindsay et al., 2012), particularly intercultural communication (Düringer & Döring, 2012; Hollan, 2012). However, despite recognizing the potential importance of empathy in resolving miscommunication, there remains a significant gap in the literature concerning its comprehensive role within different intercultural communication contexts (Clark et al., 2019; Cuff et al., 2016).

Addressing this research gap is important, as it has the potential to facilitate mutual understanding and collaboration among individuals from diverse cultural backgrounds. Moreover, gaining a deeper insight into the role of empathy in intercultural interactions can yield practical benefits across various domains, including service-providing contexts such as healthcare contexts.

This study examines the empathic communication processes of service providers and how they perceive the outcomes of these processes in a specific intercultural context, namely, that of intercultural interactions between Western/Westernized healthcare providers and patients who are newcomers to Canada from Arab Middle Eastern countries. Additionally, this research emphasizes capturing the providers' level of behavioural cultural intelligence, as it may play a

pivotal role in ensuring that empathy is expressed and effectively communicated across cultural boundaries.

Theoretically, this study makes two key contributions to the empathy and cross-cultural communication literatures: 1. Identification of Empathic Behaviours: This study goes beyond the abstract concept of empathy and pinpoints the specific verbal and nonverbal behaviours that healthcare service providers may employ to effectively express empathy to their patients from diverse cultural backgrounds. It offers a detailed examination of these behaviours, contributing to a more nuanced understanding of empathic communication in intercultural contexts; 2. By investigating the role of cultural intelligence in this overall process, this study may also inform how to enhance intercultural understanding and cooperation even in the absence of prior culture-specific training or knowledge.

Practically, the findings of this research can serve as a foundation for developing training programs and policy guidelines for interventions. These resources can be tailored to healthcare professionals and organizations engaged in intercultural interactions, offering concrete strategies and techniques to foster empathic communication, thereby making these resources actionable and practical. In a world that is becoming increasingly globalized and polarized, promoting positive intercultural experiences is paramount. This study aligns with this broader societal need by offering practical solutions to bridge cultural gaps and facilitate meaningful connections (Maddux et al., 2021).

The subsequent sections of this paper delve into the literature and the underlying theoretical underpinnings that guided the empirical investigation and describe the methodology employed in the study and the resultant findings. The paper concludes with an in-depth analysis of the findings and how the discovered insights contribute to advancing theory and practice.

Literature Review

Changing Immigration Trends: Implications for Communication in Healthcare Contexts

The most recent data from Statistics Canada (2016) indicates that newcomers comprise a considerable segment of the Canadian population, accounting for 21.9%, with Ontario hosting the largest concentration at 29.1%. While Canada has historically prided itself on being a nation of immigrants, the increasing diversity of immigration sources has presented service providers with significant challenges in ensuring high-quality caregiving for immigrant clients (Carroll et al., 2007). Similarly, the question of how to deliver culturally sensitive healthcare that supports newcomers' successful integration and fosters a sense of belonging has gained prominence and is vital for the overall well-being of newcomers and the broader Canadian community.

Indeed, from the standpoint of healthcare service providers, intercultural communication represents one of the foremost challenges reported in caring for immigrant patients. For example, in a study about pediatricians who cared for immigrant families with disabled children (Lindsay et al., 2012), the pediatrician interviewees recounted facing communication barriers when interacting with the immigrant families of their patients, which led to adverse outcomes, including difficulties in establishing trust.

These challenges are highly problematic because poor interactions during healthcare visits represent a potential risk factor for deteriorating health among immigrant populations (Kennedy et al., 2015). Substandard or inappropriate interactions can result in immigrant patients withholding crucial health information, refusing care (Ahmed et al., 2016), fearing providers (Ahmed & Bates, 2017) or failing to comply with treatments (Lindsay et al., 2012). In essence, a better patient experience may be associated with improved patient safety and health outcomes in

general (DiMatteo et al., 2012; Stewart, 1995; Yeheskel & Rawal, 2019) and for immigrant patients in particular (Kennedy et al., 2015; Lu & Ng, 2019).

How healthcare providers interact with their patients plays a pivotal role in shaping the overall patient-healthcare provider experience. To underscore this significance, Hollan (2012) introduced a theoretical perspective highlighting the importance of studying empathy within specific contexts. This approach sheds light on how empathy can be crucial in facilitating interactions among individuals from diverse cultural backgrounds. Similarly, Ahmed et al.'s (2016) comprehensive review suggests that healthcare providers can mitigate communication barriers and enhance the quality of caregiving experiences through empathic techniques, even without culture-specific training.

However, it is regrettable that research also indicates that these encounters often suffer from "lapses" in empathy (Lamancuso et al., 2016, p. 429). When empathy is not consistently enacted, or healthcare providers lack empathy training, their interactions with patients yield inconsistent results. For example, interviews with refugee patients from Burma who resettled in the United States revealed their frustration with perinatal caregivers. These patients perceived their providers as unaware of their culturally related preferences, frustrations, and insecurities (Lamancuso et al., 2016). This highlights the critical need for more effective demonstrations of empathy within the context of diverse intercultural patient-provider experiences.

While research suggests that conveying empathy in intercultural interactions holds promise for improving the overall patient experience (Yeheskel & Rawal, 2019), there is limited available research on how empathy is effectively demonstrated within diverse intercultural patient-provider experiences. Accordingly, a substantial gap remains in understanding and

effectively implementing empathy in the context of healthcare interactions with patients from various cultural backgrounds.

In summary, healthcare providers face challenges with intercultural communication, and overcoming these challenges via empathic communication may be helpful. However, the question of how healthcare providers conceive of empathic intercultural communication remains unclear, as does the understanding of how they strive to approach it or self-evaluate their effectiveness at it. Because intercultural healthcare communication is, at its essence, a cross-cultural communication process, empirical evidence for how to improve cross-cultural communication, in general, may also prove informative to enhancing empathic intercultural communication. It is, therefore, crucial to explore the cultural intelligence (CQ) literature, which has amassed considerable evidence about the utility of CQ for cross-cultural communication effectiveness.

Cultural Intelligence (CQ) and Why It Matters

Early and Ang (2003) introduced the concept of CQ, defining it as an individual's capacity to behave and manage effectively in culturally diverse settings, taking into account intercultural differences stemming from variations in race, ethnicity, and nationality (Ang & Van Dyne, 2015; Earley et al., 2006; Fang et al., 2018; Ng et al., 2012). Thus, CQ encompasses the ability to interact successfully with individuals from different cultures (Alon et al., 2016), adopt appropriate cultural behaviours (Crowne, 2013), and function effectively in challenging cultural environments (Ang & Inkpen, 2008). Unlike generalized intelligence, such as IQ, CQ is not considered a fixed trait. It is acknowledged as a dynamic capability that can be developed through targeted interventions (Ang & Van Dyne, 2015; Leiba-O'Sullivan, 1999).

The pertinence of CQ to intercultural communication contexts can be best understood through uncertainty reduction theory (Berger & Calabrese, 1975) and social exchange theory (Cropanzano & Mitchell, 2005). Uncertainty reduction theory posits that in situations characterized by uncertainty, such as initial interpersonal communication between individuals from different cultures, parties seek different types of information (i.e., cues) to reduce uncertainty. As uncertainty decreases, the quality of interpersonal communication is expected to improve. Social exchange theory suggests that as interpersonal communication progresses, the increasing interdependence between individuals leads to the development of high-quality relationships and an expectation of reciprocity.

CQ contributes to these two processes by enabling individuals to develop heightened awareness about tolerating and managing intercultural ambiguity. This awareness, in turn, may also promote a culture of empathy or be enriched by empathic techniques within service provision contexts. Ultimately, a greater capacity to manage intercultural ambiguity can enhance the quality of intercultural communications, bridge the gap between cultural differences and foster a deeper connection with clients or patients.

Dimensions of Cultural Intelligence

Conceptually, CQ is rooted in Sternberg's (1986) theory of multiple foci of intelligence within an individual. Hence, scholars have consistently noted that CQ is a multidimensional construct (Ang et al., 2007; Fang et al., 2018), encompassing cognitive, affective, and behavioural components. The four dimensions recognized in CQ are Metacognitive CQ, Cognitive CQ, Motivational CQ, and Behavioural CQ (Earley & Ang, 2003). Although these dimensions collectively contribute to an individual's overall CQ, they are argued to operate independently (Rockstuhl & Van Dyne, 2018).

Metacognitive CQ involves the ability to think about one's thinking. It encompasses self-monitoring and the capacity to adjust one's thought processes as needed. Specifically, metacognitive CQ requires a high level of self-awareness and the ability to address one's biases, underlying beliefs, and frames of reference that may influence intercultural behaviours (Ang et al., 2007). For instance, individuals with high metacognitive CQ can recognize when they employ stereotypes and modify their thoughts about diversity to mitigate potentially biased decision-making.

Cognitive CQ relates to factual knowledge about cultures in general and, ideally, the specific culture with which one interacts. This dimension is typically developed through training interventions that educate individuals about cultural similarities, differences, and acceptable norms. Individuals with high cognitive CQ can quickly retrieve information about cultural norms, beliefs, and appropriate behaviours when needed (Yamazaki & Kayes, 2004). For example, in a culturally diverse setting, an individual with high cognitive CQ will swiftly access information regarding acceptable levels of eye contact and personal touching based on the other person's culture.

Motivational CQ refers to the willingness to invest effort and resources into learning about diverse cultures and effectively applying that learning in various situations and contexts (O'Sullivan, 2017). It is generally agreed that motivational CQ is influenced by an individual's personality, with extroverted and open-to-experience individuals more likely to exhibit high levels of motivation to interact with representatives from different cultures (Peng et al., 2015). Conversely, individuals scoring low on extroversion and openness to experience may display lower motivational CQ due to their inclination towards less outgoing and interculturally engaging behaviours.

Behavioural CQ is the only observable dimension of CQ. It refers to demonstrating appropriate verbal and nonverbal actions when interacting with individuals from diverse cultures (Ang & Van Dyne, 2015; Fang et al., 2018). Evidence suggests that individuals with high behavioural CQ can utilize a range of verbal and nonverbal behaviours they consider appropriate (i.e., expected and accepted) in evolving intercultural interactions (Ng et al., 2012).

Knowledge Gaps about The Role of CQ in Empathic, Intercultural Communication

As noted above, previous research has empirically demonstrated the contribution of CQ to the effectiveness and satisfaction of intercultural communication processes in general (Fang et al., 2018). Yet, despite this, the relevance of CQ to *short-term* interactions requiring empathic communication – such as those expected of service providers in healthcare settings - remains opaque. As other scholars have also noted, there is a need for future research to examine "single interactions—replete with micro interpersonal interactions that require live maneuvers and adaptive fine-tuning of attitudes to be successful" (Molinsky, 2007, p. 622). It is also necessary to explore how it may facilitate *intercultural* empathic communication.

In particular, behavioural CQ has received limited empirical attention among the dimensions of CQ. Thus, the specific behavioural displays encompassed within behavioural CQ remain undocumented. There is a dearth of knowledge regarding the precise range of appropriate verbal and nonverbal behaviours that contribute positively to healthy intercultural interactions within specific cultural contexts. Indeed, there is a notable research gap concerning nonverbal behaviours in organizational behaviour more broadly (Bonaccio et al., 2016). Hence, given that behavioural CQ represents the only observable aspect of CQ, investigating behavioural CQ presents a valuable opportunity to potentially gain insights into how more culturally intelligent

healthcare providers may detect and deliver nonverbal behaviours that may communicate empathy in intercultural interactions than providers with less cultural intelligence.

With the above in mind, four research questions were formulated to achieve the objectives of this study: RQ#1: How do healthcare providers conceptualize empathic communication? RQ#2: What strategies do they employ to enact this conceptualization, both behaviourally and through verbal and nonverbal communication? RQ#3: How do healthcare providers evaluate the effectiveness of their efforts in practicing empathic communication? And RQ#4: To what extent, if any, does the healthcare provider's level of behavioural cultural intelligence influence the various aspects explored in the previous research questions? The following section describes the methodology by which this study attempted to address the four research questions.

Methods

Methodological Approach

A qualitative, interpretive, and inductive approach to inquiry was employed to address the research questions, drawing on the works of Creswell and Poth (2018) and Hennink et al. (2020). The qualitative methodology allows for an in-depth exploration of the participants' experiences, beliefs, and perceptions, providing rich and contextually nuanced data that can illuminate the complex dynamics of empathy in healthcare settings. The interpretive approach recognizes that reality is not an objective entity but is shaped and constructed through social interactions, shared meanings, and the sense-making processes of individuals (Myers, 2013). Thus, by adopting an interpretive stance, this study acknowledges the subjective nature of human experiences and aims to explore healthcare providers' diverse perspectives and interpretations regarding empathy

in intercultural interactions, which is what may ultimately influence their behaviour. Given the study's exploratory nature and aim to examine the empathic communication process, the chosen qualitative inductive inquiry and explanation approaches align well with the research objectives.

Research Context

This study was conducted in Ontario, Canada, known for its ethnic and cultural diversity. Canada's Charter of Rights and Freedoms emphasizes and protects multiculturalism, promoting respect and harmony among its diverse population. In addition, because Canadian healthcare is publicly funded, it is accessible to newcomers, and significant numbers of newcomers access the public healthcare system.

The landscape of Canada's immigrant population has undergone significant changes in recent years. The Arab Spring in 2011 and the subsequent influx of Middle Eastern refugees in 2015 have contributed to a growing and remarkably diverse immigrant community. This demographic transformation brings unique challenges for healthcare providers delivering top-tier healthcare services to these newcomers.

In particular, individuals from Arabic-speaking backgrounds among the immigrant population face many obstacles when seeking healthcare services. These challenges encompass limited access to informational resources, a scarcity of language support, and various other barriers that hinder their ability to navigate the healthcare system effectively (Ahmed et al., 2016). Some of these barriers were underscored in the second paper of this dissertation. Consequently, the issue of providing appropriate healthcare services to Arabic-speaking immigrants in Canada has risen to the forefront of healthcare considerations.

This study embarks on an exploration of the perspectives held by Canadian healthcare providers to gain a comprehensive understanding of this complex issue. Specifically, it delves

into their experiences and viewpoints concerning intercultural communication with Arabic-speaking patients. This research seeks to uncover the intricate dynamics within these healthcare interactions, shedding light on the nuances, challenges, and opportunities inherent in delivering healthcare services to this diverse and growing population.

Participants

A purposeful sampling strategy was initially employed. This strategy allows the selection of participants with relevant experiences and perspectives related to the specific research topic (Miles and Huberman, 1994). This study's target population consisted of Canadian healthcare providers in Ottawa who treated or currently treat Middle Eastern Arabic-speaking newcomers to Canada, including immigrants and refugees. By applying this inclusion criterion, the sample participants were expected to possess substantial experiences and insights contributing to a meaningful exploration of empathic intercultural interactional quality. This approach aligns with the principles of qualitative research methodology advocated by Creswell and Poth (2018) and Miles and Huberman (1994).

To achieve the desired number of participants for the study, I reached out to eight community healthcare centers in Ottawa. These centers were chosen explicitly because their websites indicated they offered health and social services and resources to newcomers, including refugees and newly landed immigrants. Moreover, these centers emphasized providing services in multiple languages, including Arabic. Various methods such as email, phone calls, and reaching out through their social media platforms on Facebook and Instagram were employed to establish contact. A concise brief message outlining the study's purpose and the type of participants sought was shared with the centers, requesting they disseminate the study information among their caregivers.

The focal context was that of community healthcare centers in Ontario because they are dedicated to delivering comprehensive, ongoing primary care services, primarily catering to patients who require continuity of care and managing chronic conditions. These centers typically boast a multidisciplinary team of healthcare professionals capable of addressing diverse medical needs, including doctors, nurses, and specialists. Their core focus lies in nurturing doctor-patient relationships, managing chronic conditions, and promoting holistic health and well-being. In contrast, walk-in clinics excel in providing immediate, episodic care for minor illnesses and injuries, all without the need for prior appointments. While they offer a convenient avenue for prompt medical attention, walk-in clinics do not facilitate continuity of care or establish ongoing patient-provider relationships.

It is important to note that data collection for this study occurred during the Covid-19 pandemic (2020-2022). As a result, many institutions experienced temporary closures or offered limited services, and they were inundated with numerous phone calls and messages. In addition, healthcare providers face many challenges and experience significant strain on their time. Consequently, out of the eight centers approached, only five responded and agreed to help circulate the study information among their caregivers. Interested healthcare providers who wished to participate contacted me directly. The interviewed participants were then asked to share information about the study with their professional networks, specifically other caregivers working with the same target patient group. This combined resultant approach employed purposeful and snowball sampling techniques to recruit participants for the study.

Twenty-six Canadian caregivers were interviewed. Table 1 in the Appendix presents an overview of the participants' demographic data, and this table is discussed further in the results section.

TABLE 1 HERE

Data Collection Procedure

Semi-structured phone interviews were chosen as the data collection method for this study. This approach was deemed appropriate as it allowed for a detailed exploration of the perspectives of healthcare providers regarding empathic intercultural interactions in the healthcare context (Hennink et al., 2020). Although there are acknowledged limitations to conducting interviews over the phone compared to face-to-face interviews (Hennink et al., 2020), phone interviews were preferred due to their convenience, ensuring privacy for the interviewees, and accommodating their schedules. Moreover, conducting interviews over the phone promoted the health and safety of all participants, especially in light of the COVID-19 outbreak. The average duration of the interviews was approximately 30 minutes. In addition to the interviews, a short survey was administered via email to collect demographic and behavioural CQ information relevant to the cultural aspects of the study.

I had two compelling reasons for not using video interviewing in the context of this study: First, the primary goal of the study was to gain insight into the participants' subjective perceptions and reflections on their past lived experiences. Video interviews could introduce complexity by conveying my nonverbal cues in a different context, which may distract from the study's central objectives of focusing on participants’ reflections on the dynamics of past communication exchanges. By opting for phone interviews, the focus remained on the participants' narratives and interpretations, allowing for a more direct exploration of their experiences. Moreover, phone interviews proved effective in capturing paralanguage, including

pauses, variations in tone and emphasis, and repeated phrases or words. Such paralinguistic cues provided insightful nuances of emotional expression during the interviews without distracting the participants with the interviewer's nonverbals. This paralinguistic information was effectively noted, providing richer insights into the participants' emotional states and emphases during their narratives.

The interview protocol was developed using the critical incident technique (Flanagan, 1954). The interview questions covered participants' general impressions and reflections on their interactions with Middle Eastern immigrants within Canadian healthcare settings. Participants were encouraged to share significant positive and negative experiences they had encountered. Furthermore, participants were asked to provide their understanding of empathy and share their perspectives on improving communication to enhance the empathic quality of care for this specific patient population. After conducting the initial interviews, the interview protocol underwent revisions based on concept checking, paraphrasing, and clarifying points through discussions with the thesis advisor. Additionally, new questions were introduced to consistently explore emerging themes further (Spradley, 1979). The resulting interview protocol is presented in Table 2.

TABLE 2 HERE

I conducted, digitally recorded, and transcribed the interviews verbatim. All interviews were conducted in the English language. After transcription, participants were contacted to review the transcripts and were provided with a copy. They were given a fourteen-day window to report any modifications or changes they wished to make to the transcript.

Steps to Ensure Trustworthiness and Rigour

My perspective and strategies to mitigate bias played a crucial role in interpreting the data, as they enriched the depth and authenticity of the study in several ways:

First, my experience as a newcomer gave me a deep understanding of the challenges and emotions newcomers might have encountered. This empathy allowed me to ask relevant and sensitive probes, which captured nuanced insights that a cultural outsider might have missed. My background also contributed to my commitment to giving a voice to the Arab population to ensure the research's social relevance and impact. Hence, I remained diligent in data collection and analysis, allowing participants to share their experiences and challenges authentically.

Second, to ensure academic and institutional receptivity to the study’s findings, I rigorously adhered to the literature-derived questions in the interview protocol to ensure the trustworthiness of the data collection procedure and data analysis. I maintained consistency across all interviews, reducing potential bias that might have arisen from variations in the interview process. This methodical approach ensured that all participants had an equal opportunity to share their experiences. A cultural outsider, the thesis advisor also reviewed initial transcripts and provided feedback, adding an extra layer of critical objectivity to the data collection and analysis processes. For example, during the analysis, the advisor’s insights helped identify areas where additional probing about assumptions was warranted, effectively enhancing the study's rigour.

Finally, although member checking of the data interpretations was not conducted as systematically as it could be, participant verification was conducted in the sense that interviewees were provided with verbatim transcripts to facilitate their corrections and additional elaborations to the raw data; this was critical in ensuring the fundamental trustworthiness of the

raw data itself. This approach also allowed participants to directly contribute to interpreting their experiences, ensuring their perspectives were accurately represented.

Data Analysis

I adhered to the principles of grounded theory (Strauss & Corbin, 1990) and followed the procedures of Gioia, Corley, and Hamilton (2013) in building theory from qualitative data. I coded the data manually with the help of an Excel spreadsheet.

The data analysis examined how participants interpreted the need for empathic communication and how these interpretations influenced their subsequent verbal and nonverbal behaviours with their Middle Eastern newcomer patients. The analysis also explored their perspectives on the outcomes of empathic (or less empathic) experiences for themselves and their patients. Due to practical constraints, direct observation of the communication encounters was impossible. Therefore, the analysis primarily relied on the interview data, which were analyzed and organized into themes and sub-themes to generate new insights grounded in empirical evidence.

I manually coded the data using an Excel spreadsheet, and regular consultations with the thesis advisor were conducted to address any uncertainties and achieve agreement on coding decisions. At least 50% of the data was co-coded. In addition, the full transcripts were reviewed multiple times during the initial coding process to ensure accuracy and consistency across all transcripts. This iterative comparison and revision of codes helped shape the development, merging, or exclusion of themes as deemed appropriate (Hennink et al., 2020).

The first-order coding concepts were advanced in the subsequent analysis phase to develop second-order themes. To achieve this, I organized the first-order concepts into specific categories, such as "attentive perspective-taking," which served as both a conceptual framework

and a practical enactment of empathy. This categorization allowed patterns to emerge and discerned that the experience of empathy evoked unique responses from both healthcare providers and patients.

The analysis results, which are visually represented in Figure 1 within the data structure, provide valuable insights into the intricate dynamics of empathy within healthcare interactions. These findings shed light on the multifaceted nature of empathetic experiences and their impact on healthcare providers and patients, offering a comprehensive view of the phenomenon under investigation. It is worth noting that within the figure, arrows indicate the connections that link first-order codes to second-order themes and further to the higher-level theoretical dimensions.

FIGURE 1 HERE

Results

Participants' Demographics and Behavioural CQ

The sample included physicians and nurse practitioners (17 participants, 65.4% from primary care), medical interpreters (5, 19.2%), and multicultural navigators (4, 15.4%) who share several commonalities within the healthcare setting, including their role in facilitating and ensuring effective communication with patients. Among the participants, eighteen (69%) identified as females. Regarding their previous experience interacting with individuals from a Middle Eastern background, only two providers had resided in a Middle Eastern country for an extended period. Furthermore, the participants evaluated the extent of prior experiences with Middle Eastern individuals in contexts outside the healthcare setting as high (9 participants, 34.5%), medium (10, 38.5%), or low (7, 27%).

Almost half of the providers interviewed (15 participants, 57.7%) reported a high level of behavioural CQ. In comparison, 10 participants scored at a medium level and one at a low level. Interestingly, regardless of their behavioural CQ scores, all participants recounted positive and highly negative encounters with patients from the identified population. For a comprehensive overview of the participants' demographic data, please refer to Table 1 in the Appendix.

The healthcare providers' narratives provided valuable insights into the complex relationship between their conceptualization of empathy, the verbal and nonverbal behaviours they enact, and the perceived resultant consequences that emerge from these interactions. First, it became evident that healthcare providers hold well-defined conceptualizations of empathic communication. They have clear ideas about the need for empathy and how it could best be expressed in their interactions with newcomers. Second, building upon their conceptualizations about how best to express empathy with newcomer Arab patients in particular, healthcare providers employed diverse verbal and nonverbal behaviours. Providers actively sought to convey empathy to their patients through their actions and words to foster a supportive and empathetic environment. Third, several providers commented on the outcomes they perceived to result from their enactments of empathic communication.

A conceptual model was developed to encapsulate these intricate relationships and findings, which is visually presented in Figure 2. This model provides a structured representation of how the conceptualization of empathy informs enacted behaviours, leading to perceived various consequences for healthcare providers and their newcomer patients. The following sections discuss these findings in more detail according to each of this study's research questions below.

FIGURE 2 HERE

RQ#1. How Does the Healthcare Provider Conceptualize Empathic Communication in Healthcare?

Participants underscored valuable insights into conceptualizing empathic communication when they think of patients from diverse cultural backgrounds. Their conceptualization emerged as multifaceted, encompassing distinct categories that they consider essential attributes of empathic communication. I grouped it into three categories: Attentive perspective-taking, caring active listening, and accommodating/empowering patients. *Attentive perspective-taking* refers to the healthcare providers' emphasis on actively understanding their patients' unique perspectives, beliefs, and cultural backgrounds. Providers mentioned putting themselves in their patient's shoes, recognizing their individuality, and considering their lived experiences and traditions as integral parts of the interaction and the challenging health/mental issues they face. *Caring active listening* signifies the providers' commitment to truly listen to their newcomer patients and convey a sense of caring and compassion. Providers described how they consciously think about creating a safe and supportive environment where patients feel heard, valued, and respected. *Accommodating/Empowering Patients* refers to the providers' intended actions aimed at accommodating the unique needs and preferences of each patient while simultaneously empowering them to take an active role in their healthcare journey. Providers, who embody this approach, attempt to adapt their communication style, treatment plans, and care delivery to align with the patient's cultural, linguistic, and individual requirements. At the same time, they foster patient autonomy by providing information, involving patients in decision-making, and

promoting self-efficacy. The following section presents a detailed description of each of these categories.

Attentive Perspective-Taking

Perspective-taking refers to the need to understand and consider patients' cultural and religious perspectives and experiences actively. Providers mentioned that perspective-taking entailed immersing themselves in their patients' situations, attempting to see the world through their patients' eyes, and learning about their cultural and religious traditions and lived experiences – pertinent to the medical/mental situation – without imposing their (the provider's) own norms and ways of doing things. Providers described their genuine interest in comprehending their patients' thoughts, emotions, concerns, and needs:

> *"So, I would [want] to be able to understand someone else's perspective and understand what they are going through. It is different from sympathy. It is not feeling bad, pity, or sorry for them [the patient]. It is just understanding they are going through something… If you do not understand them, you are not going to understand what they are going through or how to help them." (HCP6, female, nurse practitioner, High B-CQ)*

> *"Being curious to know more about the transcultural differences [is important] … Not necessarily [to] like them or dislike them, just learn and try not to judge things… If it works [for the patient], it works… You do not have to make their way of life yours; you do not even have to agree with it. Just be open to learning about it and respect the difference, as long as it does not hurt anybody." (HCP1, female, nurse practitioner, Medium B-CQ)*

> *"So just being open to conversations or understanding the patient's needs… So, like learning, listening to their experiences has been the center of how I can serve them… So, you know, just creating a space where they feel safe, where they can talk about whatever they are feeling, and then after that, also talking about what they need and how we can then serve them... Also, even being mindful not to impose our [provider's] own thoughts and our own beliefs or our own understanding onto them, but to understand what they are feeling first and foremost, and then serve them… I think not telling them what we think they need, but listening to them and seeing what they need as a group [cultural community] is very important." (HCP20, female, Multicultural Health Navigator, Medium B-CQ)*

In particular, providers recognized that the Arab population's past trauma (emotional and/or physical due to the political restlessness in their home countries) is relevant to the present medical/mental situation:

> *"Because there are not just language and cultural barriers, but they [patients] may have experienced trauma too. So that sort of affects how they are going to function once they are here and what medical issues they might have too." (HCP2, female, physician, High B-CQ)*

> *"It is not only about the symptoms that they [patients] bring up and questions around the symptoms they bring up, but also the meaning behind those symptoms or the meaning behind that story… I think it is more about hearing that story and trying to get a visual of what that story is about, and what their life was like before coming to Canada and then*

what their life is now, and understanding all the details of what that sudden change is like for them… I think that is important in developing a therapeutic relationship with a patient and for their overall health." (HCP4, female, physician, High B-CQ)

"Admittedly, I grew up in a white Canadian middle-class upbringing, so very little exposure to different socio-demographics and different ethnicities. So just kind of just listening to them [patient] talk about their experiences and what they have lived through is quite eye-opening for me... It just strikes me the amount of trauma that they come with! They give me more insight into what they have survived and what their life was like before coming to Canada, whereas before, I mean, I was really naive and did not have this background… And it is also helping me make sense as to why they might be coming in with, you know, constant headaches or back pain, or just like body symptoms [mental trauma manifested in physical symptoms], when their backs are fine on an x-ray and their tests are normal!" (HCP17, female, nurse practitioner, Medium B-CQ)

When a healthcare provider actively engages in attentive perspective-taking, they are better equipped to engage in caring active listening. By understanding the patient's cultural background, beliefs, and values, the provider can tailor their listening approach to be culturally sensitive.

Caring Active Listening

According to the providers, actively listening to their patients requires paying close attention and conveying understanding and validation through verbal and nonverbal behaviours.

The providers underscored some verbal and nonverbal behaviours that they felt would convey attentive understanding and validate their patients' experiences, thoughts and emotions:

> *"I [provider] should not only ask about the symptoms that they [patient] bring up and questions around the symptoms they bring up, but also the meaning behind those symptoms or the meaning behind that story… I should allow pauses to happen or pay attention to the emotional cues. I think [that] without these [nonverbal] behaviours, addressing the cause of the symptom would get lost." (HCP4, female, physician, High B-CQ)*

> "… So, you can do a lot more with body language. You can kind of show your concern so that they [patient] can see that you are caring and listening, and you should kind of smile occasionally." (HCP2, *female, physician, High B-CQ)*.

> *"I think one of the big pieces to show empathy is availability and presence. Like, being able to sit and hear, or having space for stuff that people are sharing, that might be difficult or challenging, or whatever… So, I should not oriented to the computer, but actually looking at the patient and creating space for people to share, or not be doing well, or whatever that is." (HCP5, male, nurse practitioner, High B-CQ)*

When a healthcare provider engages in caring active listening, they hear the patient's words and discern their emotions, concerns, and needs. This attentive listening serves as a foundation for accommodating and empowering the patient. Providers who actively listen are

more likely to recognize specific accommodations that may be required due to cultural differences or individual preferences.

Accommodating/Empowering Patients

The providers' beliefs about accommodating/empowering patients involved actions and interventions that responded to their patient's specific needs – particularly cultural or religious ones – and concerns with tangible solutions, interventions, and support to address the issues directly:

> *"I always want to be respectful of the husband [male figure] and their [couple] dynamics from a culture standpoint, and often it is not like the woman is oppressed, but it is just how they function in a family unit. But for me, I want to hear from her [she is the patient] even though she would be more than happy for him to speak on her behalf, and so again, I do not think it is necessarily an oppression thing… But, it is often a hard-to-adjust situation." (HCP9, female, nurse practitioner, High B-CQ)*

> *"I usually prefer to have a female interpreter for a female patient. I believe this is a better fit in terms of expressing the patient's needs… I think it is important to understand that this is an important part of the cultural norm." (HCP13, female, nurse practitioner, High B-CQ)*

> *"I understand and find that family dynamics often interfere with caregiving and I am mindful of this when a patient comes with their family… I also find that it is really hard for them [patients] to acknowledge mental health, but not all of them. I have some clients who are very open to mental health issues and illness, but I have to address the mental*

health topic differently because they are just not as open or as receptors a mental health diagnosis as I hope." (HCP17, female, nurse practitioner, Medium B-CQ)

"I try to introduce to them [patient] that we have translation services, and to provide a high level of confidentiality, as well as making sure everybody has autonomy, to communicate the health concerns, without fear… Number one is to establish and create a clear line of communication. And in the process, my goal is just to make sure they feel that they are supported… I try to provide avenues for them to interact with me, to make them comfortable, and to build trust with me as a practitioner." (HCP15, female, nurse practitioner, Medium B-CQ)

Furthermore, some providers acknowledge the fragility associated with cultural considerations in patient care. This recognition highlights the provider's awareness that cultural factors can significantly impact how patients perceive and engage with healthcare services. This recognition also underscores the uncertainty about how to approach a situation involving a patient from a different cultural background, fearing it may lead to miscommunication or misunderstanding:

"I do not know what I would do [the type of accommodations/empowerment to extend]. Because I think that if I confronted them [patient], they would just leave and not receive the care they deserve… It is so fragile when it comes to cultural things… If you go too fast, you risk breaking the trust; if you do not go slowly enough, you can lose the situation and not be able to talk to the person anymore. You must keep the trust alive without damaging it; that is key." (HCP1, female, nurse practitioner, Medium B-CQ)

The three categories of attentive perspective-taking, caring active listening, and accommodating/empowering patients reinforce and enhance each other, creating a seamless, patient-centred approach to care that respects cultural diversity, fosters genuine understanding, and empowers patients to participate actively in their healthcare journey. The three categories of empathic conceptualization reported by the providers are interwoven, forming a robust foundation upon which providers can effectively enact empathic communication.

RQ#2. How Do Providers Attempt to Enact Their Conceptualization of Empathic Communication Behaviourally, Verbally and Nonverbally?

Providers shared numerous instances of how they put empathy into practice when interacting with Arab patients in an intercultural healthcare environment. They specifically highlighted the preferences of this cultural group for particular verbal and nonverbal behaviours during these interactions. I maintained the use of the three categories of empathic conceptualization, as they closely aligned with how providers enacted empathy. These categories include perspective-taking, caring active listening, and accommodating/empowering patients. Each facet of the providers' empathic enactment involved unique strategies to effectively convey empathy, as detailed below and supported by illustrative quotes.

Enactment of Attentive Perspective-Taking

Enacting perspective-taking entailed healthcare providers conversing with their patients to gain insight into their cultural traditions and personal life experiences. In the context of caring for Arab patients, providers were particularly attentive to the unique cultural preferences that characterized this patient group. These preferences encompassed a range of aspects, including dietary restrictions, distinctive communication norms, considerations related to gender modesty,

expectations regarding the caregiver's role, and attitudes toward mental health issues. The following quotes exemplify how these cultural preferences were acknowledged and respected by the providers:

"*So based on what country they come from, and if they are Arabic speakers, not always, but often they are Muslims. So, for example, my [Arab Muslim] patients who are diabetic, I make sure that I ask them about Ramadan, and whether they are planning to fast, and how do we plan ahead for that, for example? Or most likely, they are not going to be drinking alcohol, or if I am asking about diet, I do not ask about pork. So, there are certain things that I try to be mindful that are religious or cultural for those patients... My female patients who are veiled, I have to remember to talk to them about vitamin D. So that is just something that I think is in the back of my mind when I see this patient population... But what is interesting to me is I have Muslim patients from the opposite gender, and I assumed a lot of them would want to switch to same-gender providers. But we often have this conversation that they are allowed to see providers from any gender as long as it is for medical reasons… But I always ask [about each Arab patient's preference for same gender provider]." (HCP2, female, physician, High B-CQ)*

"When it is the female member of the family [who is the patient], I almost always find a male partner who wants to join us and interact on her behalf. So at that time, we usually communicate this way: I am going to use fake names… So I have Bill and Sherry. When I called Sherry, Bill decided to come in. I'll say "Oh, I would like to see Sherry. Bill can wait for her in the waiting room." Oftentimes, he will say,"No, Sherry cannot communicate. Iwill talk to you, even when we use an interpreter!" That is when I say

"Oh, Bill, do not worry, I have an interpreter with us. They will be able to help me. Sherry, are you okay with that?" If she says yes, Bill can wait outside, and I can proceed with the consult. I have to respect that. If Sherry says "No, I want to be able to have Billy in the room." I will have to accommodate it, too. This situation presents itself many times when I am interacting with this population." (HCP15, female, nurse practitioner, Medium B-CQ)

"When I have to talk to a female patient and discuss the results of a pelvic exam, a Pap test, etc. When I call the interpreting service, and I get a male interpreter, I will say "I'm sorry, I want to have a female interpreter for my patient."" (HCP19, female, nurse practitioner, Medium B-CQ)

"I think one of the big ones I ask about is probably modesty and stuff… Arab people seem to be a lot more modest, especially women, you know, they want to have everything covered. Oftentimes, we need to remove articles of clothing in order to do different procedures or examinations… I have to ask about what they are comfortable with." (HCP6, female, nurse practitioner, High B-CQ)

"I have families with lots of little children, as well. So when we are doing consults with the children, it is also a time for me to see and learn about some of their cultural practices and behaviours with the children." (HCP7, female, nurse practitioner, High B-CQ)

Furthermore, providers made a point to inquire about their patients' lived experiences, including any emotional or physical trauma they may have endured before arriving in Canada. Providers recognized the significance of this line of inquiry, as it afforded them insights into their patients' journeys and the potential relevance of past trauma to their current medical or mental health conditions. In other words, this approach allowed them to connect the dots between their patients' past experiences, both positive and challenging, and their current healthcare needs.

For example, a patient who has experienced trauma in their home country might exhibit specific psychological or physical symptoms requiring specialized care or treatment sensitivity.

> "*I try to also ask individually if they want to share what kind of experiences, they have had... Because there are not just language barriers and cultural barriers, but they may have experienced trauma too. So that sort of affects how they are going to function once they are here and what medical issues they might have too." (HCP2, female, physician, High B-CQ)*

> *"I asked her [patient]. I said: "I see that there is something very emotional going on. Can you tell me what is bringing up all these tears?" She said: "I am just thinking about how they treated me in the hospital [in her home country] and how they told me that it was in my head, and you are telling me that it is not in my head." To me, that was such a poignant moment for her to have been able to be heard for the first time and to be taken seriously for the first time… Because so much of her suffering was due to not just the physical symptom but how that has impacted her life and her view of herself because she had been rejected, etc. If I only addressed the symptom, I would not necessarily have treated the whole picture." (HCP4, female, physician, High B-CQ)*

> *"One of the early things I do is just to say to the patient, "I am really interested in what your medical concerns, but today, I am hoping that I can just get a sense of who you are, where you are coming from, and what kind of concerns that you have. Then on the next visit, we will start addressing these concerns directly."… So for me, that first visit is really critical to establish that stuff and get a sense of that person, who they are and where they are coming from… That is my goal, and the rest comes later." (HCP5, male, nurse practitioner, High B-CQ)*

In summary, the enactment of perspective-taking involved healthcare providers actively seeking to understand and accommodate the diverse cultural backgrounds of their Arab patients. Simultaneously, the practice of inquiring about patients' lived experiences and past trauma served as a valuable tool for healthcare providers to grasp the full scope of their patients' health conditions. These two perspective-taking approaches aim to foster a deeper level of cultural competence and sensitivity, recognizing the significance of cultural backgrounds and personal experiences in shaping their patients' healthcare needs and experiences.

Enactment of Caring Active Listening

Despite the ambiguity and challenges of interacting with patients from diverse cultural backgrounds, providers elaborated on their efforts to convey active listening both verbally and nonverbally to encourage patients to express their concerns and emotions freely. I categorized the verbal behaviours into three categories: Acknowledgements through using empathetic statements, paraphrasing and seeking clarifications when the situation necessitated it.

In terms of acknowledgements, providers relied on a repertoire of empathetic statements. They perceived these statements as demonstrating genuine understanding and acknowledging the

patient's feelings and experiences. For example, they would use acknowledgments to validate the patient's emotions and perspectives, such as saying, "I understand that this situation must be challenging for you."

> *"A patient was acting differently than usual. And then I came to find out that his town was really bombed that day, and he was really worried about other family members there… I went in and I apologized to him. And I said: "I am very sorry, that I did not think to ask you about that." I felt really bad. But it also helped our relationship afterwards... because of that acknowledgement that you know some kind of suffering has occurred, whether it is emotional, physical, or mental." (HCP7, female, nurse practitioner, High B-CQ)*

> *"Just acknowledging with them [the patient], like, how hard that must be your situation or how challenging it must be or frustrating, even when it comes to stuff like they are here in Canada, but if they cannot have say, physiotherapy for their back pain, or maybe they cannot see specialists, you know, and just how frustrating that that must be to have come here, like hoping for a better life in better care. However, there are still these challenges." (HCP17, female, nurse practitioner, Medium B-CQ).*

> *"I would try to suggest to him [the patient] a bunch of different things we could do… At the end of the conversation, I had to say, "We are going to do the best we can; this is what I can do: A, B, and C. But unfortunately, there is not a whole lot more we can try." (HCP2, female, physician, High B-CQ).*

Providers also employed paraphrasing to confirm their comprehension of the patient's expressed. This involved restating the patient's words or summarizing their concerns to ensure they accurately grasped the intended meaning.

> *"I feel like the good encounters [with a specific Arab patient] were when I have listened intently, and really repeated things and showed that I remember and that I care, because I have taken good notes and I have reviewed them before the appointment so that I am not asking about something that was brought up before." (HCP3, female, physician, High B-CQ)*

> *"If it is unclear, I will ask my question slightly differently. So I rephrase my question in a different way, and then my patient is able to answer it [through the interpreter]. Sometimes, they have the very same answer, or sometimes it is a little bit clearer for what I'm asking... For a patient who is of a Middle Eastern background, even if they have the same issues as Canadians, I will need to repeat their concerns and make sure that, okay, so you know what this medication is for…, you know that your bottle is almost empty, we need to get a new one from your pharmacy, can you bring it next visit. So this takes a bit longer, just to make sure that all the ducks are in a row to be able to do a treatment at the appropriate time." (HCP19, female, nurse practitioner, Medium B-CQ)*

In addition, a few providers mentioned a *reverse paraphrasing* technique. This technique involves providers asking the patient to reiterate what the provider has just discussed. The purpose of this practice is to confirm whether the patient has understood and interpreted the

information in the same way the provider intended. Essentially, it is a way for providers to ensure that their message has been accurately received by the patient:

> *"I will maybe offer some information, feedback, advice, prescription, whatever it is, but then I will ask that patient to say it back to me, so that I have a good sense that they understand what I am saying, rather than just accepting if they are nodding; that is not quite enough, depending on how important that information is." (HCP5, male, nurse practitioner, High B-CQ).*

Furthermore, providers were attuned to the importance of seeking clarifications when circumstances demanded it. Rather than making assumptions or proceeding with incomplete information, they proactively asked questions to clarify any ambiguities or uncertainties. In their view, this facilitated a more accurate understanding of the patient's perspective and conveyed a sense of genuine interest and engagement in the patient's well-being.

> "When I am looking at, say, the ears of somebody with a hijab, then sometimes they will only show me the tiniest part of their ear. So sometimes I just ask, is it okay if they put the hijab behind your ear, or is it okay if I touch your ear? Almost always, it is totally fine. It is just that there might be a little bit of discussion or negotiation around it at first." (HCP5*, male, nurse practitioner, High B-CQ).*

> "I do not touch them [patient] without their permission, and I do not get in their personal space without their permission. So asking and having respect for them and their preferences definitely." (HCP6, female, nurse practitioner, High B-CQ)

These three verbal strategies collectively contributed to the providers' efforts to convey active listening verbally.

Providers also described their utilization of several nonverbal cues as a significant component of their efforts to convey acknowledgment and empathy during healthcare interactions with Arab patients. These nonverbal behaviours included maintaining eye contact, adjusting their paralanguage, nodding/smiling, using their time patiently, offering supportive resources and respecting personal space.

> *"I address my patient and I look at my patient… My body language is towards my patient, and I am listening, and I am looking at my patient while they're explaining their symptoms, current condition, or what issue they are dealing with… Maybe I take more time for the appointment to ensure the information has been received clearly. And that the information that I am giving to the patient has been received as well. So just giving more time would be the difference... I think they [Arab patients] need more time, whether it is to dress and undress or allow for interpretation to happen. You just need more time. And to be listening to be really listening." (HCP19, female, nurse practitioner, Medium B-CQ)*

> *"I always make sure that like when speaking to them that I do not speak to the interpreter, you know, like I make eye contact with the patient. And then the interpreter does the translating." (HCP17, female, nurse practitioner, Medium B-CQ)*

> *"For this Arab patient, I think eye contact is super important… Any kind of mirroring is always helpful. So I tend to do that, and I tend to be, I think, pretty good at that… when I*

feel that there is a bit of formality, I also back off a bit, leave a bit more space, speak in a less cheery tone, more even, a little bit softer voice, all that… Actually, that is maybe something I do more with patients from Arab countries is to speak with a bit of a softer voice." (HCP3, female, physician, High B-CQ).

"I definitely smile. I would generally try to shake a hand, prior to COVID, I generally try to shake a hand, smile, invite them to sit before I speak, I introduced myself. I try to acknowledge them, like I speak to them and not the interpreter and I try to watch and look at the whole family like everyone who is there and look for their reaction… If I have my stethoscope for example, and I am listening to their lungs, I usually put my other hand that is not holding my equipment; I put that either on their shoulder or shoulder blades or arm just so that it is not just equipment touching them." (HCP9, female, nurse practitioner, High B-CQ)

"When she [patient] started crying, I passed her a box of tissues, but I remained silent for a period of time because I thought she would tell me why she was crying. I think a whole minute or two passed… So, there were no interruptions during this crying moment (HCP4, female, physician, High B-CQ)

In addition, one provider shared a unique approach by mentioning that their healthcare center's caregivers mirror modesty in clothing as a nonverbal way to convey care. This practice aligns with cultural modesty expectations and communicates respect for the patient's cultural values:

"We [caregivers at a specific community healthcare center] pay attention to modest dress. So not a lot of plunging necklines and bare shoulders and dresses over knees. So having a more professional look, though not every single person does this, but certainly [modesty] is something we tried to ensure because many patients have a more modest display of the body as well." (HCP7, female, nurse practitioner, High B-CQ)

The healthcare providers believed that these various nonverbal cues collectively contributed to creating an environment of empathy and understanding during healthcare interactions, ultimately enhancing the quality of care received by Arab patients in the intercultural healthcare setting. In the next section, I consider the providers' elaborations on how they accommodate/empower their Arab patients.

Enactment of Accommodating/Empowering Patients

The "accommodating and empowering" category represents a set of strategies healthcare providers employ to address cultural differences effectively and empower their Arab patients. I broke down this category into three aspects. First, using humour, providers recognized the potential of humour as a valuable tool in bridging cultural gaps, establishing rapport and lightening patients' tension:

"One thing that I really enjoy is humour. I can think of several examples where Arabic-speaking patients had a laugh, which is especially wonderful when you are working through an interpreter because sometimes it is a little bit harder to connect because everything is getting interpreted. But despite that, I still had some really fun interactions. For example, I have a patient who is from Palestine, him and his wife and his little kids recently arrived. He was telling me in this encounter that he just loves snow. I told him,

"Well, that is fantastic; maybe you can help shovel your neighbours' driveway." He had a good laugh, and his wife laughed really hard at that as well... So there have been many different encounters like that, where people were able to laugh. Just humour itself is not something you can fake, you cannot fake laugh really in a way that is genuine, and it immediately breaks down barriers." (HCP5, male, nurse practitioner, High B-CQ)

"He [patient] and I would have a little joke here or there to kind of break the ice." (HCP2, female, physician, High B-CQ)

"Sometimes I would make a joke about it [provider's clothes] being a space suit or something like that to try and put them [patient] at ease." (HCP8, female, nurse practitioner, High B-CQ)

Second, when faced with language and cultural barriers, providers take steps to bridge the communication gap by utilizing medical interpreters, accompanying family members, accommodating nonharmful requests, and employing nonverbal communication, such as paralanguage/vocalics, eye contact and body language.

"There are probably you know, still some patients whose English is not strong enough to, to do a proper assessment to be thorough. So in that case [one Arab patient with limited language proficiency], we would use a telephone interpreter. Originally, we had in-person interpreters, that would come to accompany the patient to their visit. But then we switched over, probably four years ago over to a telephone interpretation service. So if I

was seeing the client in person, that we would dial the interpreter on the phone, and they would be in the visit by phone." (HCP7, female, nurse practitinoer, High B-CQ)

"I ended up calling her [patient's] son; I believe it was her son or her daughter. And they were able to help translate a little bit. I am not sure if it was a different accent or dialect, but they were able to help clarify things a little bit. It did end on a better note than using the translator phone [who failed in easing the communication] and where things were then." (HCP6, female, nurse practitioner, High B-CQ)

"Families are very close, I would say, and supportive of one another… We have a mom who usually comes with three kids at a time. So, we actually take care of all kids, even those who were scheduled to be seen, but we need to make sure that their health needs are addressed as well. So that is part of what we are swinging, dealing with." (HCP19, female, nurse practitioner, Medium B-CQ)

One patient asked me, for example, to write letters for housing. I tell them housing does not look at these letters, in terms of trying to get housed faster. But people want me to write these letters, and I used to tell them it is not going to change your queue, but now I write them. Because then it shows that I do care, I do want them to get faster housing or better housing or safer housing, and why not write that letter? Maybe it will do something." (HCP3, female, physician, High B-CQ)

"I try to emphasize more with my eyes and with the tone of voice my expressions." (HCP8, female, nurse practitioner, High B-CQ)

"I adapt some of our tools and our evaluations for landmarks and development goals for children, because we use a lot of very Canadian or Western types of tools. These tools we use are not always adapted appropriately to some families with different practices like the ones we see from the Middle East." (HCP7, female, nurse practitioner, High B-CQ)

"I work a lot with telephone interpreters. For example, with an Arab patient, using paralanguage/vocalics, I do not say "I'm going to fax your requisition to the laboratory, you can go there, and then they'll send me the results electronically." Instead of saying that full sentence to the interpreter to pass to the patient, maybe I would just say, "I am going to fax the requisition to the laboratory." Then they interpret, and then I say, "You do not have to take anything." Then they interpret that. "They will send you the result automatically, you do not need to bring anything back to me." Then they will interpret that. So, I guess I will just try and keep it really simple, and just make sure that we are going along like that." (HCP5, male, nurse practitioner, High B-CQ)

Third, healthcare providers emphasized the critical role of education in empowering their Arab newcomer patients. They dedicated time and effort to explaining various aspects of the healthcare process in a way that they perceived was culturally sensitive and easy for the patients to understand, ensuring that patients were well-informed and actively involved in their healthcare decisions.

"I always try to explain at the beginning of a visit, why are we here today? What do you hope to accomplish at today's appointment. I try to be as open and honest as possible, trying to meet their needs. But also identify any of the areas that I have concerns about that I would like to talk about as well." (HCP7, female, nurse practitioner, High B-CQ)

" I explain my role. I explain that anything they tell me is confidential, and it is just to do with their health. And I am not going to be sending any report to immigration [IRCC]… [Also] there have been times when I have people from this population coming with lots of things they want to address. And I have had to say, "I understand that you have got a lot of things you want to talk to me about today. But we only got half an hour. Would you like to give me your whole list and then choose a priority? Or do you want to tell me what you think is the most important thing?" And usually, people get it. Sometimes it deescalates the situation there, and they are like, "Oh, okay. I did not know" (HCP8, female, nurse practitioner, High B-CQ)

"I tell them [patient], there is no good food to introduce, it is what you eat at home that is good. So I cannot tell you to introduce potatoes if what you eat at home is Couscous... What I can tell you is to introduce high-iron food, I do not care what it is… I think putting the fact that I do not have the answers, they (recipient-patients) do—they are the persons that have the better answers for their children." (HCP1, female, nurse practitioner, Medium B-CQ)

"I always ask my female patients from this population if they would feel more comfortable to have a female provider to do the pap test. So for this patient, we have a great rapport, but she did say "yeah, it would be nice to have a female provider." I did all of the history, and then my female colleague did her pap test." (HCP5, male, nurse practitioner, High B-CQ)

I leave the door open and I say [to the patient], if this is something you think about or want to discuss, you are free to come and speak to your doctor about this. Whenever you feel it is a convenient time for you, or whenever you feel you have decided on this." (HCP19, female, nurse practitioner, Medium B-CQ)

"A big component of what I do is health education. Health Education through empowerment, not the top-down education or the approach that those patients do not know anything; I build on what they already know, I empower them to get to know the services available to them, and the rights and responsibilities in the healthcare system, because, for many services, they do not know the existence of many services or how to get to many health services. And there is huge frustration around this happening. So, education through empowerment helps lessen the frustration and ease the transition for newcomers to settle more easily (HCP11, male, Multicultural Health Navigator, High B-CQ).

In summary, the accommodating and empowering category encompasses a range of strategies that healthcare providers use to address cultural differences and empower their

patients. These strategies include leveraging humour to create rapport, accommodating barriers to communication, and providing patient education. By incorporating these approaches into their practice, providers aim to deliver more effective, culturally sensitive, and patient-centred care for Arabs in an intercultural healthcare setting. In the next section, I consider the providers' perspectives on the outcomes of their efforts.

RQ#3. How Do Providers Assess the Effectiveness of Their Empathic Communication Efforts?

In their narratives, healthcare providers highlighted several consequences resulting from their efforts in practicing empathic communication with Arab patients who are newcomers. These consequences encompassed both the perceived outcomes for the patients and the providers themselves. It is important to note that the interview protocol specifically prompted providers to share negative and positive examples. I delve into each of these highlighted outcomes below.

Patient Outcomes: Quality Caregiving Relationship

Healthcare providers believed that empathic approaches to newcomer Arab patients led to several beneficial consequences for the patients, including engagement, adherence to treatment plans, enhanced family involvement, and trust in understanding/adhering to the medical requirements. As the following sample quotes will illustrate, they underscore the significance of empathy in cultivating a therapeutic alliance that optimizes newcomer healthcare outcomes.

Patient Engagement. Patient engagement refers to the extent to which patients actively participate in their healthcare experience and actively manage their health. This outcome can include their involvement in decision-making about their treatment, adherence to medical advice, and overall engagement with healthcare providers and services. Providers observed that their

empathic approaches played a role in facilitating better patient engagement among their newcomer Arab patients. For example, many noted that their Arab patients typically began their relationship with the caregiver with considerable hesitation about providing sensitive/personal health information: *"I got the sense that they [newcomer Arab patients] were always reluctant to share at the beginning." (HCP3, female, physician, High B-CQ)*

In addition, getting their Arab patients to talk about their mental health (and any struggles they were living with) was challenging for providers. The lack of English language proficiency further perpetuated this barrier: *"I think that there is a lot of stigma among this population, like, there is a lot of bad stigma around mental health, and having those conversations around mental health, are never easy, they do not come easy. And they [patient(s)s] do not give us information, especially when communicating through an interpreter. So I can say I genuinely do not get a good, thorough or honest talk with my mental health patients while working through an interpreter." (HCP9, female, nurse practitioner, High B-CQ)*

Nevertheless, through intentionally displaying empathy to the patient, many providers noted a gradual transformation in patients' willingness to overcome their hesitations and disclose personal information about their health concerns. They described this distinct shift in their patients' willingness to share information openly as follows:

> *"It was nice that she finally trusted me with that [telling the provider personal background information that affects her mental and physical health]. That helps inform my ability to serve her, so I know that maybe this small thing that she is reacting to, maybe that is within this larger context that is so important, and what she is thinking about at home." (HCP5, male, nurse practitioner, High B-CQ)*

"And then [after I, the provider, demonstrated empathy] they tell me that… they have had…let's say diabetes, or high blood pressure for years. But they only had the medication they were able to carry with them [from their home country/refugee camp]…Then they were in transit and lost it or it was stolen or they ran out and they are very worried because they have not had their medicine… they started sharing!" (HCP8, female, nurse practitioner, High B-CQ)

"They [patient] started asking questions… they ask for opinions. I had patients that… like to show how they live and what they can do. Our conversations are not only limited to like, "Okay, what is your health problem?", you know, or "What is your mental health problem?". They kind of bring more of like their personality, I would say, and are super open to feedback." (HCP10, female, nurse practitioner, High B-CQ)

The providers also perceived that demonstrating empathy prompted their patients to express their emotions more openly. This emotional expression appeared to give patients a sense of relief:

"The tears [expressed by the patient] were both of pain because she obviously was reliving that painful experience, but maybe also of joy in some sense or relief in some sense, that she was now being adequately listened to… I could tell that it was something very novel to her and that she was so appreciative." (HCP4, female, physician, High B-CQ)

"I remember that this [the provider's acts of validation and empowerment] brought tears into her eyes [patient's] and she was calmer. It may not look like a breakthrough, but to

me, it was great progress… Empowering them [another Arab patient] made them open up and find the words to advocate for themselves. They had a positive emotional reaction." (HCP11, male, Multicultural Health Navigator, High B-CQ).

Additionally, the provider's use of empathic approaches appeared to tangibly improve the cordial quality of communication between providers and Arab patients. Providers perceived that their patients felt more comfortable and relaxed in their communication, and they had positive exchanges in an environment of *"safety, kindness, friendliness, interest in the other person as a person." (HCP5, male, nurse practitioner, High B-CQ).* Providers also discerned a positive quality to the caregiving relationship when the patient felt comfortable enough to use humour and/or thank the provider following a consult:

"So, at the end of the appointment, she [patient] shook my hand and said, "Thank you so much, Dr. You are so wonderful; I am so happy you are my doctor." So that was a good ending… She was quite happy." (HCP2, female, physician, High B-CQ).

"Sometimes they [patient] will really thank you. I had this one patient, she was like, "Oh, thank you!" No one ever said it to me like that before. Sometimes, they are very, very grateful." (HCP20, female, Multicultural Health Navigator, Medium B-CQ)

"Then the patient returned [after they finished the procedure] to my office where I was sitting, looked at me, and said to me: "So I am not pregnant!" I knew she was joking [because she was over 65 years old], but it was absolutely hilarious… She was so relaxed." (HCP5, male, nurse practitioner, High B-CQ)

Conversely, providers acknowledge that there were limits to the extent of empathic accommodations/empowerment they could provide even if they wanted to. In such instances – which typically arose when the provider faced constraints which they felt unable to work around – the patients expressed anger to the point that some were verbally dismissive/aggressive:

> *"I guess she [patient] wanted to have a very concrete answer to her problems, but I could not provide that. So, she got really angry and left. I remember it was very dramatic because she said that I was the worst doctor and she walked out of the room, and out of the hallway and yelled "Worst doctor! Worst doctor! Worst doctor!" all the way out." (HCP3, female, physician, High B-CQ)*

> *"They [patient] got very upset. And they demanded services/resources over and over again. I have to keep repeating that this is not something I have the power to do and I will not do it." (HCP8, female, nurse practitioner, High B-CQ)*

In other instances, the patient's dismay was not expressed quite as vigorously but was still evident. The patient may not have explicitly voiced their discontent or frustration; subtle cues or indicators in their behaviour, tone of voice, or body language suggested they were not entirely satisfied or comfortable with the healthcare interaction or the empathy they were receiving:

> *"It is not that he [patient] hung up on me, but he was quite blunt and said, "well, whatever! Thanks a lot." Then he kind of hung up on me but did not really hang up on me; he still was relatively polite, but he definitely was not happy with the situation." (HCP2, female, physician, High B-CQ)*

"The thing is—and I do not know if this is an Arab culture thing, I have no idea—but he would never get overly angry or upset with me, other than a bit of tone. But he would never say the words like "You are not doing what I need you to do or what I want you to do." But I kind of felt like that is what he was feeling. Then, I found out later that he was saying that to a psychologist I had referred him to." (HCP5, male, nurse practitioner, High B-CQ)

The quotes above demonstrate that healthcare providers, despite their sincere attempts to practice empathy in their interactions with patients, encountered certain unclear or ambiguous limitations that might have hindered the patients' overall experiences of empathy. In essence, the patients may not have been aware of the constraints or challenges the providers were navigating within the healthcare system. Thus, they blamed the providers for any perceived lack of empathy.

Adherence to Treatment Regimens. Providers highlighted that employing empathic approaches had a positive impact on patient adherence to treatment regimens. They observed that Arab patients when feeling validated and supported through empathy, demonstrated greater commitment to their scheduled appointments and stronger adherence to prescribed treatment plans. This included faithfully following medication regimens and implementing recommended lifestyle changes.

"They [patient] do not want to miss the appointment, and they want to follow up. They do not always agree with our plan together but are more willing to try it." (HCP2, female, physician, High B-CQ)

"It might be just as simple as somebody actually using the medication that I had discussed with them, or it might be a patient going to their specialist appointments as agreed to. Whatever it is, victories are smaller than large." (HCP5, male, nurse practitioner, High B-CQ)

"Once he [accompanying male spouse] got more familiar with her [female patient] coming to our clinic more regularly, and because he trusted our center and knew me, she was able to commit to her psychology appointments. He would come to the clinic with her and sit in the waiting room [before that, he refused to let his wife do the consult alone or be seen for mental health issues]. And that seemed to be an agreeable way to approach it [the treatment]." (HCP7, female, nurse practitioner, High B-CQ).

However, when some providers noted that their empathic attempts did not fully accommodate the patient's cultural and medical needs, it led to some patients changing their providers:

"I have felt that as a woman provider, with some adult or older men patients, that there is a little bit of distrust; there was something, and I did not feel good about it… In one case, this one man was very upset because I was a couple of minutes late, and I wondered if that was because I was a woman. I do not know, I got that sense. He got transferred to a male provider later because things were not working with me, and I think that worked out better for him." (HCP3, female, physician, High B-CQ)

Positive Family Involvement in the Care Journey. This category refers to the active and supportive participation of a patient's family or close relatives in the patient's healthcare and treatment process constructively and beneficially, such as participating in discussions and decision-making. Some providers recognized the cultural and practical significance of family support and involvement in decision-making processes among Arab patients. The involvement of family members was aligned with the patient's cultural values and provided more holistic support in the form of social support networks. Accordingly, those healthcare providers realized that an empathetic approach to care necessitated an inclusive approach with patients and their families. Those who adopted this approach were able to establish a collaborative relationship with the family members: Family members felt more included and valued in the care journey, leading to increased trust and cooperation between providers, patients, and their families:

> *"I think that the four-month-old appointment [of their baby who was the patient] was very positive for the father, in that it created a positive link… I think that my [provider's empathic approach] surprised him because maybe he was expecting me to try to push the American way of doing it [feeding and nurturing the baby] or the Canadian way of doing it… The father continued to come with the mother and baby and every time he came to see me in the following appointments, which are quite frequent in the first year of life of the child, he was like "Hello, Dr. How are you?" Like, he was so happy to see me, I could feel that it [the interaction and relationship] was very positive (HCP1, female, nurse pratitioner, Medium B-CQ)*

Trust in Patient's Capacity. Trust in a patient's capacity reflects a healthcare provider's belief in the patient's ability to actively participate in their care, make informed decisions, and

take action to improve their health. Several providers noted that their use of empathic approaches enhanced the development of trust in the patient's capacity to participate actively in their healthcare journey. Specifically, they perceived their empowerment techniques allowed patients to engage in shared decision-making, take ownership of their health, and actively collaborate with the provider to manage their care:

> *"Over time, I trust that they [patient] can communicate, has the autonomy to communicate and decide and make the better decision for their own body." (HCP15, female, nurse practitioner, Medium B-CQ)*

> *"They [patient] were not always great at following up for appointments, taking their medication, and doing everything independently. But they became somewhat better probably [at owning their actions] because we have that relationship established… They are now more willing to try the plan because we have that trust that developed both ways; it takes time to develop that trust for them and me." (HCP2, female, physician, High B-CQ).*

In summary, empathic communication is pivotal in fostering better quality caregiving relationships between healthcare providers and their newcomer Arab patients. When healthcare providers employ empathic approaches, they observe several positive outcomes from their patients: Patient engagement, treatment adherence, collaboration with families, and trust in the patient's capacity to manage their health actively. These outcomes collectively contribute to better healthcare experiences and improved patient health outcomes.

Provider Outcomes: Intercultural Self-efficacy

Several healthcare providers shared that their empathic approaches toward newcomer Arab patients yielded positive outcomes for themselves, ultimately enhancing their intercultural self-efficacy. These outcomes were grouped into two categories: Their capacity to alleviate compassion fatigue and burnout and their competence in providing care to Arab patients. These outcomes are elaborated upon below to provide a more comprehensive understanding.

Mitigation of Compassion Fatigue/Burnout. For the providers who discussed this outcome, the ability to mitigate compassion fatigue and burnout means effectively managing and reducing the emotional exhaustion, stress, and psychological strain that can result from providing care to patients, especially in challenging, ambiguous, or emotionally demanding situations. It meant that they were capable of empathizing with the newcomer patients' emotional challenges without abandoning the professional boundaries necessary to avoid/reduce burnout and compassion fatigue:

> *"I try to maintain the situation as much as I can… While being able to compartmentalize, not internalize whatever is going in, I can be objective and help the patient calm down… We are trained providers, we should manage those difficult situations." (HCP15, female, nurse practititoner, Medium B-CQ)*

Nevertheless, a few providers acknowledged the occasional difficulty they experienced when doing this:

> *"I think what is hard is when a situation seems revolting to me, then I am not in empathy. Empathy is meaning I am not immersed into my feelings. But when a situation is not fair, for a child, or an elderly, for a woman, or for a man—it can be any of my patients—it is*

hard because my feelings and my values of life get in the way, and it consumes my energy. I bring it home, I bring it in my dreams; I bring it everywhere... Compassion fatigue, that is how it is called... I know a lot of healthcare providers who are in that situation. They have been so empathic and present to others that they cannot do it anymore; they are worn out." (HCP1, female, nurse practitioner, Medium B-CQ)

"He [patient] was extremely complex medically, and he was extremely complex on a psychological or emotional level. I found that I just could not give him enough time, because I just felt like he really just needed constant care. I do not know exactly how to describe it. But it is just like, it was really difficult to the point where I felt like maybe a bit of a relationship breakdown… As a provider, you think that if somebody asks you something and you do it, they will be happy about that. But it did not exactly work that way. So that left me with some stress, burnout, or whatever it was; it was just kind of challenging." (HCP5, male, nurse practitioner, High B-CQ)

"I had tears as well [following the consult]." (HCP17, female, nurse practitioner, Medium B-CQ)

Clarity about How to Care in an Empathic Intercultural Communication. For healthcare providers who pointed to this outcome, having clarity about how to care in empathic intercultural communication means having a clear understanding and a well-defined approach to delivering care in an empathetic and culturally sensitive way when interacting with patients from the Arab population. The providers noted that they developed confidence in their capacity to

address the unique needs and experiences of Arab patients. In other words, when their perceived empathic approaches to their Arab patients were effective, it contributed to a virtuous cycle reinforcing their self-efficacy to communicate empathically effectively:

> *"It was satisfying to look after them [patients] and make sure that they felt comfortable with the plan and knew where to go to get treatment... I did have the resources, and I was able to direct them to the right resource to get the treatment." (HCP6, female, nurse practitioner, High B-CQ)*

> *"I forget what country this gentleman was from, but he was, he was Middle Eastern, but he was deaf. And his sign language that he spoke was different from ASL like American Sign Language. So I had to get two interpreters, one interpreter who, who was deaf himself, and he understood this language that the patient was speaking. And he interpreted from that sign language to ASL. And then we had an ASL English speaking, language speaking interpreter who turned the ASL into words and spoke… I was confident in coordinating the translations. And I asked him "Is there anything else I can help you with?" I wanted to do more for him." (HCP9, female, nurse practitioner, High B-CQ)*

> *"I became adept at navigating difficult [cultural] situations and getting the outcome I think is best for the patient and me." (HCP15, female, nurse practitioner, Medium B-CQ)*

> *"It is interesting [to the provider] how I had learned to adjust care [to fit the Arab patient]." (HCP7, female, nurse practitioner, High B-CQ)*

On the other hand, a few healthcare providers shared that they encountered confusion and uncertainty when they encountered difficulties in effectively conveying empathy to their Arab patients. When these providers found it challenging to express empathy as intended, they felt unsure how to proceed with the interaction involving their patients. This sense of uncertainty resulted from not having a clear or complete understanding of the appropriate methods and strategies to communicate empathy effectively. In essence, they felt uncertain about the best course of action when faced with such communication challenges.

> *"It is so fragile when it comes to cultural things, it is all about culture. If you go too fast, then you break the trust; if you do not go slowly enough, you can lose the situation completely and not be able to talk to the person anymore. You have to keep the trust alive without damaging it… So if I confront too much, I am going to lose that patient. If I do not do anything, then I might lose the patient too because they won't have the trust to tell me what is going on. It is so hard [to know how to navigate the situation to ensure empathy is effectively conveyed]." (HCP1, female, nurse practitioner, Medium B-CQ)*

In summary, the healthcare providers' perceived effective enactment of empathy to their Arab patients enhanced how they effectively manage compassion fatigue and gain clarity on how to provide empathetic care to Arab patients. This improved self-efficacy signifies their increased confidence and competence in delivering culturally sensitive and empathic healthcare to patients from Arab backgrounds.

RQ#4: How Does the Healthcare Provider's Level of Behavioural CQ Influence the Above Aspects, If at All?

All healthcare providers in the study demonstrated an ability to recognize empathic cues, contributing to their competence in navigating intercultural interactions effectively. This means they were adept at identifying and understanding nonverbal and verbal signals of empathy in their interactions with Arab newcomer patients. Evidently, they could discern when empathy was being conveyed during these exchanges. However, it is worth noting that, regardless of their scores on behavioural cultural intelligence (CQ) – a measure of their ability to adapt to and interact effectively with individuals from different cultures – and despite their ability to describe positive interactions with Arab patients, all participants also shared accounts of negative interactions they had experienced with these patients. In other words, they encountered challenges and difficulties in specific interactions, which did not align with their generally high levels of behavioural CQ.

While only a few participants mentioned particularly challenging interaction situations that left them uncertain about how to proceed, all participants experienced some degree of challenge despite their moderate to high behavioural CQ levels, which is a significant observation. It suggests that these challenges were not limited to a select few but were encountered by healthcare providers across the board. The specific challenges providers faced in these interactions were detailed in the findings for the previous research questions in the study. These challenges represent potential communication breakdown or misalignment points that deserve further investigation and possibly targeted interventions.

The study highlights areas where healthcare providers, even those with strong intercultural competencies, may encounter difficulties in intercultural healthcare interactions.

Thus, this observation emphasizes the need for ongoing research and support in addressing these challenges effectively. In the following section, I summarize the findings of this study and discuss their implications in light of the literature.

Discussion

In today's globalized world, Western countries are experiencing increasing diversity due to the influx of immigrants and refugees seeking permanent resettling and accessing different service-provision contexts (Maddux et al., 2021), including healthcare services. These individuals come from diverse cultural backgrounds, bringing unique beliefs, practices, and challenges in accessing and navigating the healthcare system (Ahmed et al., 2016). Recognizing the empathic quality of interactions between healthcare providers and newcomer patients is important for delivering culturally sensitive and patient-centred care that addresses the specific needs of these populations.

While some studies have explored empathy's role in overcoming communication barriers and enhancing service experiences without culture-specific training in healthcare contexts (e.g., Ahmed & Bates, 2017; Ahmed et al., 2016), there is a pressing need for more extensive research to investigate the nuanced dynamics of empathy in intercultural interactions thoroughly. In the absence of such research, ill assumptions and stereotypes about specific visible populations may prevail (Simich et al., 2009), not to mention inadvertent neglect of the healthcare needs of those populations. Emic-focused research (that can be adapted to diverse populations, cultures, settings, and contextual factors) is needed precisely to ensure that current research conclusions in the literature that claim to be etic (universal) are, indeed, universally applicable. In light of these considerations, this study has focused on examining the processes of empathy within the specific

context of intercultural interactions between Western/Westernized healthcare providers and Middle Eastern newcomer patients in Canada.

Summary of Key Findings

Concerning the first research question (How does the healthcare provider conceptualize empathic communication?), this study showed that the providers are aware of the relevance of empathy to their intercultural interactions with newcomer patients. Providers identified their understanding and conceptualization of empathic communication as multifaceted and encompassing three categories: attentive perspective-taking, caring active listening, and accommodating/empowering patients. Attentive perspective-taking highlighted the importance of providers actively engaging in understanding and considering their patients' perspectives and lived experiences. Providers who demonstrated attentive perspective-taking were willing to genuinely immerse themselves in their patients' situations, seeking to see the world through their patients' eyes. Caring active listening emphasizes the significance of attentive and compassionate listening. Providers acknowledged the importance of caring and active listening and aimed to create a safe, non-judgmental environment where their newcomer patients feel heard and understood. These providers utilized effective communication skills, such as maintaining eye contact, nodding in agreement, and employing verbal cues, like paraphrasing and summarizing, to ensure accurate understanding. The third category, accommodating and empowering patients, highlighted the providers' intended actions and interventions in response to specific needs and concerns expressed by their patients. Providers with this tendency sought solutions, interventions, or support to address the patient's concerns and alleviate the patient's distress.

Valuable insights were obtained regarding how the providers enacted their principles of empathic communication, which addresses the second research question (How do providers attempt to enact this conceptualization behaviourally, verbally and nonverbally?). The findings

addressed the enactment of the three key categories of empathic conceptualization: Attentive perspective taking, caring active listening, and accommodating/empowering patients, each encompassing distinct strategies utilized by the providers to demonstrate empathy effectively. For the enactment of perspective-taking, providers recognized the significance of understanding their patients' cultural traditions and lived experiences, as these factors influenced their beliefs, values, and healthcare preferences. Providers demonstrated a genuine interest in comprehending their patients' perspectives by actively and proactively seeking information about cultural practices, beliefs, and customs. This approach allowed providers to understand their patient's unique experiences better and tailor their care accordingly. Second, for active listening, providers acknowledged the importance of attentive listening and utilized verbal and nonverbal cues to demonstrate their engagement and understanding. Verbal cues such as affirmations, reassurances, and paraphrasing were employed to convey care and demonstrate active listening. Nonverbal cues, including maintaining eye contact, nodding, adapting paralanguage/vocalics, and choosing modest clothing, were also used to convey empathy. This way, providers created a safe and supportive environment, encouraging patients to express their concerns and emotions freely. Finally, for the enactment of accommodating/empowering their patients, providers accommodated cultural differences. They recognized the role of humour in lightening patients' tension and establishing a positive rapport to foster trust and comfort. When faced with language barriers, providers overcame the communication gap by utilizing interpreters or simplified language. Education also played an important role in empowering patients, as providers took the time to explain medical options, procedures, and treatment plans in a culturally sensitive manner, ensuring that patients were well-informed and actively involved in their healthcare decisions.

In addressing the third research question (How do providers assess the effectiveness of their empathic communication efforts?), the study revealed two main categories of outcomes arising from empathic communication: Perceived consequences for the patients and consequences for the providers. First, regarding the consequences for the patients, an important consequence of their empathic approaches to Arab newcomer patients was establishing a higher-quality caregiving relationship. The enactment of empathy created a supportive and non-judgmental environment where Arab newcomer patients felt valued, heard, and understood, as perceived by their caregivers. As a result, patients exhibited higher levels of information sharing, which enabled them to take a more active role in managing their health and well-being. Providers noted that the empathic approaches also positively influenced patient adherence to treatment regimens. When patients felt understood and supported, they were more likely to adhere to prescribed treatment plans (e.g., follow medication regimens and implement lifestyle changes). This improved adherence may be attributed to the trust and confidence developed within the caregiving relationship and the patient's perception of providers as empathetic and invested in their well-being. In addition, providers noted that empathic approaches facilitated positive family involvement in the care journey of immigrant patients. Providers acknowledged the cultural significance of family support and participation in decision-making processes among Middle Eastern populations, as documented in the cross-cultural literature (Hofstede, 2001; Trompenaars & Hampden-Turner, 2012). Providers established a collaborative and inclusive approach to care by engaging empathetically with patients and their families, which enabled family members to feel more included and valued in the care journey, leading to positive exchanges between providers, patients, and their families. Finally, empathic approaches fostered the development of the provider's trust in the patient's capacity. As healthcare providers' empathic empowerment of

their patients contributed to improved patient engagement, adherence to treatment plans, and overall better health outcomes, the providers’ trust emerged, further facilitating shared decision-making, encouraging patient ownership of health, and active collaboration with the provider in care management.

Providers also acknowledged several valuable outcomes stemming from their empathic practices that directly benefitted them. These included the effective management of the provider's boundaries, specifically regarding compassion fatigue and burnout, as well as the reinforcement of the provider's capacity to deliver personalized care. Regarding the first point, providers demonstrated a growing proficiency in managing their boundaries regarding emotional reactions and time allocation. They recognized the crucial importance of this skill in sustaining themselves while empathizing with the emotional challenges faced by Arab newcomer patients.

Additionally, this study revealed an emergent outcome: strengthening the provider's self-efficacy as a direct result of their perceived effectiveness in empathic interactions. Providers reported that actively engaging in empathic practices enhanced their confidence and competence in understanding and addressing the unique needs and experiences of Arab newcomer patients. This increased self-efficacy equipped them to navigate complex healthcare encounters more easily and effectively, ultimately improving patient care.

Finally, to address the fourth research question (How does the healthcare provider’s level of behavioural CQ influence the above aspects, if at all?), the analysis revealed that regardless of the scores obtained on behavioural cultural intelligence, all participants recounted notable positive and negative encounters and consequences with Arab newcomer patients. These challenges represent significant concerns that warrant further examination. From a practical standpoint, it is imperative to adopt a comprehensive approach involving various stakeholders,

including the healthcare system, to eliminate the barriers these newcomer patients face and support their healthcare providers. Such a collaborative effort can influence empathic interactions within intercultural healthcare settings.

Theoretical Contributions

The findings of this study fill a gap in the existing literature by shedding light on the challenges healthcare providers face when working with Arab patients and providing detailed insights into how providers navigate these challenges to deliver empathic care effectively and their perspective on the resultant outcomes for themselves and their patients. However, it does more than fill gaps in the literature – it advances theory in the field. This section considers the key theoretical contributions of the four key research questions addressed.

This study advances our understanding of Canadian healthcare providers' understanding of empathic communication – both the importance of it and the strategies they use to enact it. Although the research was conducted in the context of servicing an under-researched community of newcomer patients in the Canadian healthcare system (Arab newcomers), the theoretical and practical implications of this important topic are much broader, contributing valuable insights due to its in-depth look at the conceptualization, behavioural enactment, assessment, and impact of empathic communication. Thus, this study offers significant and actionable contributions to the literature and society.

More specifically, in terms of theoretical contributions to the cross-cultural management literature, this study found that all participants, regardless of their behavioural cultural intelligence (B-CQ) level, reported positive and negative intercultural interactions and acknowledged a range of positive and negative consequences. It thus underscores the crucial but neglected role of empathy in bridging cultural gaps and improving communication, even when

individuals lack in-depth cultural knowledge or competence about specific cultures. The providers' assessments reveal how empathy can transcend cultural barriers and positively influence intercultural interactions. This is a significant contribution because prior cross-cultural management research has primarily emphasized the role of cultural intelligence (CQ) (Ang & Van Dyne, 2015; Ott & Michailova, 2018) while underestimating or neglecting entirely the role of the affective side of intercultural communications (apart from the acknowledgement of motivational CQ as a component of overall CQ).

This study also offers several theoretical contributions to the literature on empathic communication. First, this study's examination of providers' conceptualization of empathic communication represents a novel and valuable multifaceted framework for understanding how empathic communication is expressed in a service provider context, where each category represents a distinct dimension of empathic communication. Specifically, it identifies three key categories of empathic behavioural enactment that promise positive consequences for patients and providers: attentive perspective-taking, caring active listening, and accommodating/empowering patients. These three categories provide a more organized framework of previously disorganized literature regarding empathic communication. In addition, the caring active listening and accommodating/empowering recipients categories are relatively new to the literature, which has traditionally focused on perspective-taking as the primary component (Clark et al., 2019; Cuff et al., 2016).

Organizing these categories in a structured manner offers a more encompassing theoretical lens for researchers. This structured framework can be used to develop models and theories that better predict and explain empathic communication in specific situations, ultimately advancing the field's theoretical underpinnings. In addition, from a practical and actionable

angle, well-organized literature can greatly benefit training and practice. Considering these three categories, educators can use this framework to teach healthcare providers how to express empathy effectively. It can also be used as a performance assessment tool.

Second, the broadened recognition of verbal and nonverbal expressions pertinent to this process of empathic communication, identified by this study, offers greater insight into the behavioural flexibility providers may need to demonstrate to effectively communicate empathy across diverse intercultural populations. It highlights the importance not only of cultural awareness (as suggested by the cross-cultural management literature (Ott & Michailova, 2018)) and not only of active listening (as previously suggested by the empathic communication literature, but elaborated here with more nonverbal detail) but also the importance of nonverbal signals of tangible accommodation. For example, a prior study by Schim, Doorenbos, and Borse (2005) employed the Cultural Competence Assessment tool, a 26-item instrument designed to measure cultural diversity experience, awareness, sensitivity, and competence behaviours among healthcare providers. However, this tool fails to address the verbal and nonverbal behaviours associated with educating and engaging patients during consultations – a key discovery in the present study in accommodating and empowering patients. Consequently, omitting these educating and engaging behaviours from the tool can hinder theoretical understanding and practical application. This limitation restricts the tool's ability to evaluate and promote comprehensive, empathic communication. As a result, it may lead to an incomplete assessment of healthcare providers' competencies in this critical domain, potentially resulting in less effective patient care and a diminished patient-centred approach. The tool may also inadvertently promote a narrow focus on cultural competence at the expense of other essential aspects of patient care.

Third, this study also expands our understanding of the various enactments' behavioural and emotional consequences for patients and healthcare providers. Specifically, it highlights patient outcomes such as establishing high-quality caregiving relationships, improved patient adherence, increased family involvement, and developing trust as significant consequences for patients. For providers, it emphasizes the effective management of boundaries, enhanced self-efficacy, and the ability to deliver personalized care as outcomes of empathic practices.

From the patient outcomes angle, in a previous study by Ahmed and Bates (2017), the role of healthcare providers' cultural competency in alleviating patient fear was examined. The study's results offered some evidence that certain forms of physician accommodation of cultural differences were linked to a decrease in patients' fear of physicians. However, it is important to note that this study did not consider the potential confounding factor of family involvement in mitigating patient fear and facilitating high-quality interactions. Furthermore, when extracting insights from this study, individuals from individualistic societies may inadvertently overlook the significance of these omitted factors for the well-being of collectivist patients. In other words, the importance of these specific outcomes for the overall health and satisfaction of collectivist patients may not be immediately apparent to those more accustomed to an individualistic societal perspective.

Furthermore, a meta-analysis study (Sinclair et al., 2017) focusing on the provider's perspective unveiled a distinct stress response known as compassion fatigue, which affects many healthcare providers. However, this meta-analysis did not delve into the crucial role of empathic communication, meaning that prior studies included in this meta-analysis did not provide insights into this aspect. Empathic communication, or the absence thereof, is potentially vital in managing provider boundaries effectively, as noted by the present study. The meta-analysis failed

to discuss how empathic communication may be a key factor in addressing and preventing compassion fatigue. Consequently, this omission might lead to the oversight of an essential link between provider empathic care and provider burnout. This oversight has the potential to hinder the progression of more comprehensive studies exploring how empathic communication can effectively mitigate burnout among healthcare providers.

Although this study focuses on empathic communications with an Arab newcomer patient population, the above theoretical contributions also point to a variety of practical contributions that can inform healthcare policies, training programs, and practices aimed at improving the quality of care for all patients from diverse cultural backgrounds as well as at supporting the wellbeing of healthcare providers, more specifically, given that 1. Countries are becoming more diverse with continuous influxes of newcomers; 2. Intercultural interactions are becoming more prevalent as a result, and 3. Cultures differ in their communication norms and expectations, the potential for intercultural miscommunication is significant, and evidence of such miscommunications has been documented (Maddux et al., 2021). Hence, this study’s insights (about how providers empathically communicate in intercultural contexts) can help inform efforts to improve a broader range of provider-patient interactions than previously considered and ultimately mitigate newcomers’ adverse health outcomes (which have social and economic costs).

Limitations of The Study

No study is without limitations, and several should also be noted here. First, this research used purposive and snowballing sampling techniques to focus on the Canadian context and the experiences of Western/Westernized healthcare providers in Canada with their Middle Eastern immigrant patients. Therefore, the findings may not be generalizable to other cultural or

healthcare settings. The dynamics of intercultural interactions and the role of empathy may vary across different countries, cultures, and healthcare systems. Future research should aim to explore these dynamics in a broader range of contexts to ensure the robustness and applicability of the findings.

Furthermore, this study employed a qualitative approach, which is valuable for exploring the nuances and complexities of the empathic quality of interactions. However, qualitative research is limited in terms of generalizability and statistical power. The findings are context-specific and may not apply to a larger population. Complementing qualitative research with quantitative studies would provide a more comprehensive understanding and allow for exploring relationships and patterns at a broader scale.

Second, this research relied on self-reporting and retrospective data from interviews with Canadian healthcare providers. While interviews allow for in-depth exploration of experiences and perceptions, they are subject to potential biases such as social desirability or recall bias. Participants may have provided responses that they believed were expected or recalled their experiences selectively. Additional research methods, such as observations or surveys, could provide a more comprehensive and objective understanding of empathic interactions.

Third, the research examined the consequences of empathic approaches from the perspective of healthcare providers. However, it did not directly include the voices and experiences of their Arab newcomer patients, nor did it explore the long-term outcomes for these patients. Incorporating their patients' perspectives would provide a more balanced and comprehensive (or paired/matched view) understanding of the empathic quality of interactions. Future research should aim to match the perspectives of providers and patients regarding the

same critical incidents to capture the full complexity of these interactions and their consequences.

In addition to the above considerations, because the focus of data collection in this study was on healthcare providers who interact with community healthcare centers (which involve more extended continuity of care and longer-term consultant relationships), no data were collected regarding their first impressions and related interpretations in walk-in healthcare delivery clinics. Yet, first impressions formed during these brief encounters can impact how providers perceive the patients and their expectations and needs. In acknowledgement of this, future research may benefit from studying interactions in walk-in clinics to identify communication barriers or issues that may also need addressing within this context.

Furthermore, a longitudinal approach to research in this area may offer valuable insights into the enduring impact of empathic interactions. Examining the long-term consequences of such interactions on healthcare providers' behaviours, patient satisfaction, treatment adherence, health outcomes, and overall well-being is crucial. It allows us to establish the sustained effects of empathic care on outcomes over time, providing a more comprehensive understanding of the enduring benefits of empathic healthcare practices for all parties involved in the communication.

Finally, member-checking was constrained prior to thesis submission due to time constraints. Although the researcher obtained some respondents' immediate validation during the data collection process (paraphrasing or summarizing what the participant had said to confirm her understanding of the participant's intended meaning), this was not done systematically. To remedy this oversight, before journal publication, the researcher will compile and disseminate a summary of the findings (in the form of themes that have emerged from the data) and subsequently review these findings with willing participants to confirm whether the summarized

findings accurately represent their experiences. Any needed corrections will be noted in further iterations of this manuscript.

Future Research Directions

Several additional research directions can be proposed to advance the understanding of this important topic further. First, conducting comparative studies across different cultural and healthcare contexts would be helpful to explore how empathic interactions vary across diverse populations. Insight into the processes by which diverse cultures, cultural values, and social norms can shape empathic interactions can only strengthen our understanding of the cultural factors influencing empathic intercultural communication. From a practical standpoint, such studies can help identify similarities and differences in empathic practices and inform the development of culturally sensitive training programs for healthcare providers.

Practical Implications (for Healthcare Providers, Immigrant Patients, & Patient Communities)

Despite the above limitations, this paper has advanced understanding of the role of empathy in intercultural interactions. Employing empathic techniques can foster inclusive environments that promote intercultural understanding and cooperation, even in situations where language proficiency (Yeheskel & Rawal, 2019) and culture-specific training or knowledge are limited. This raises practical implications for several stakeholder groups, including healthcare providers, cultural community organizations, healthcare organizations, and the broader healthcare system, which are discussed below.

First, healthcare providers should strive to understand immigrant patients' cultural backgrounds, beliefs, and healthcare preferences to deliver culturally sensitive care. This can better equip them to establish a positive rapport with immigrant patients from different cultural

backgrounds by respecting cultural differences (e.g., regarding maintaining eye contact). However, even in the absence of such cultural knowledge, providers can still cultivate effective empathic communication skills, both verbal and nonverbal, that demonstrate empathy. These skills include active listening, using empathetic statements, adopting open body language, and accommodating language barriers (e.g., by utilizing interpreters or visual aids when necessary). In addition, providers can foster trust by being transparent, involving patients in shared decision-making, and empowering them to participate actively in their healthcare journey. By demonstrating empathy and respecting patients' autonomy, providers can thus strengthen the therapeutic alliance.

Second, cultural communities can serve newcomer patients by encouraging them to engage in healthcare actively by expressing their concerns, preferences, and values to their cultural community associations. Cultural community representatives can then advocate for their community by collaborating with providers to develop personalized treatment plans (e.g., by providing interpreters or cultural mediator services if needed) and by guiding patients to healthcare providers who demonstrate cultural competence and empathic care. Building strong support networks can help address language barriers and cultural challenges and facilitate better communication with healthcare providers.

Third, healthcare organizations should offer training programs incorporating empathy training to equip providers with the necessary skills to deliver empathic care to immigrant patients. This training should focus on understanding cultural diversity, effective communication strategies, and self-reflection to enhance empathic interactions. Training programs should also emphasize cultural competence education, including awareness of cultural norms, values, and

healthcare disparities. This would enable providers to be better educated about immigrant patients' unique challenges and equipped with strategies to address them.

Finally, healthcare policymakers can develop systemic policies prioritizing cultural competence and empathic care in treating immigrant patients. Policies can include guidelines for language assistance services, cultural competency training requirements, and support for providers to deliver patient-centred care. Policymakers should also ensure that resources are allocated to address language barriers, provide interpreter services, support cultural mediators, and promote diversity and inclusion by recruiting and retaining healthcare professionals from diverse backgrounds. A representable healthcare workforce that reflects the patient population may facilitate a better understanding, but even in the absence of such representation, the availability of accessible and culturally appropriate healthcare resources, such as interpretation services, can enhance the quality of care for immigrant patients. These initiatives would also improve the work experience of providers who engage in intercultural care.

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Appendix

Table 1. *Participants' Demographics*

Participants	Occupation	Overall Experience Assessment	Living in a ME Country (Yes = 1; No = 0)	Experience with MEs (Low = 1; 2 = Medium; 3 = High)	Gender	Behavioural CQ Score	Behavioural CQ Category
HCP1	Nurse Practitioner	3	0	1	F	14	Medium
HCP2	Physician	3	0	3	F	23	High
HCP3	Physician	3	0	2	F	21	High
HCP4	Physician	3	0	2	F	23	High
HCP5	Nurse Practitioner	3	0	3	M	24	High
HCP6	Nurse Practitioner	3	0	2	F	25	High
HCP7	Nurse Practitioner	3	1	3	F	25	High
HCP8	Nurse Practitioner	3	0	2	F	21	High
HCP9	Nurse Practitioner	3	0	1	F	24	High
HCP10	Nurse Practitioner	3	0	2	F	21	High
HCP11	Multicultural Health Navigator	3	1	3	M	25	High
HCP12	Medical Interpreter	3	0	1	F	21	High
HCP13	Nurse Practitioner	3	0	1	F	20	High
HCP14	Medical Interpreter	3	0	3	F	20	High
HCP15	Nurse Practitioner	3	0	3	F	16	Medium
HCP16	Medical Interpreter	3	1	3	F	20	High
HCP17	Nurse Practitioner	3	0	2	F	18	Medium
HCP18	Medical Interpreter	3	0	2	M	11	Low
HCP19	Nurse Practitioner	3	0	2	F	19	Medium
HCP20	Multicultural Health Navigator	3	0	2	F	17	Medium
HCP21	Multicultural Health Navigator	3	0	1	F	15	Medium

HCP22	Medical Interpreter	3	1	3	M	18	Medium
HCP23	Multicultural Health Navigator	3	0	2	M	20	High
HCP24	Physician	3	0	1	M	18	Medium
HCP25	Physician	3	0	1	M	19	Medium
HCP26	Physician	3	0	3	M	16	Medium

Table 2. *Interview Protocol*

Topics	Interview Questions and Probes
Context	What can you tell me about your role? a. What is your job title? b. How would you describe the work you do at your job? c. How would you describe your clientele? d. How did your role change when you started interacting with Middle Eastern clients? e. Are there parts of your interactions with this clientele that you particularly like? Other aspects you do not enjoy? Why both?
Positive example	Can you think of any examples where you were happy/satisfied with the interaction between you and the other Middle Eastern/Arabic-speaking client? a. Why did this example resonate with you? b. How did you act? Describe your behaviour? c. What kind of verbal and nonverbal signals did you use? Why? d. How did the client respond? e. Did these exchanges cause you to behave differently afterwards? Why? How?
Negative example	Can you think of any interactional examples that were negative? Why do you consider these exchanges were unpleasant? a. What happened during these exchanges? b. How did you act? Describe your behaviour. c. What kind of verbal and nonverbal signals did you use? Why? d. How did the client react verbally and nonverbally? e. How did these encounters influence your behaviour afterwards? What examples can you think of?
Concluding remarks	1. What can you tell me about "empathy"?

a. Can you think of reasons why empathy could influence exchanges between persons from different cultures? How? Why?

2. What do you remind yourself of when you interact with persons from a culture different than yours?
3. What would you tell persons from different cultures to be mindful of when they interact with a newcomer?
4. Can you think of other important things about cross-cultural interactions for newcomers and I haven't asked you about?
5. Are there other examples you'd like to share?
6. Can you think of people in your professional network who could talk to me and would be willing to? Would you forward my recruitment message to them?

Figure 1. *Data Structure*

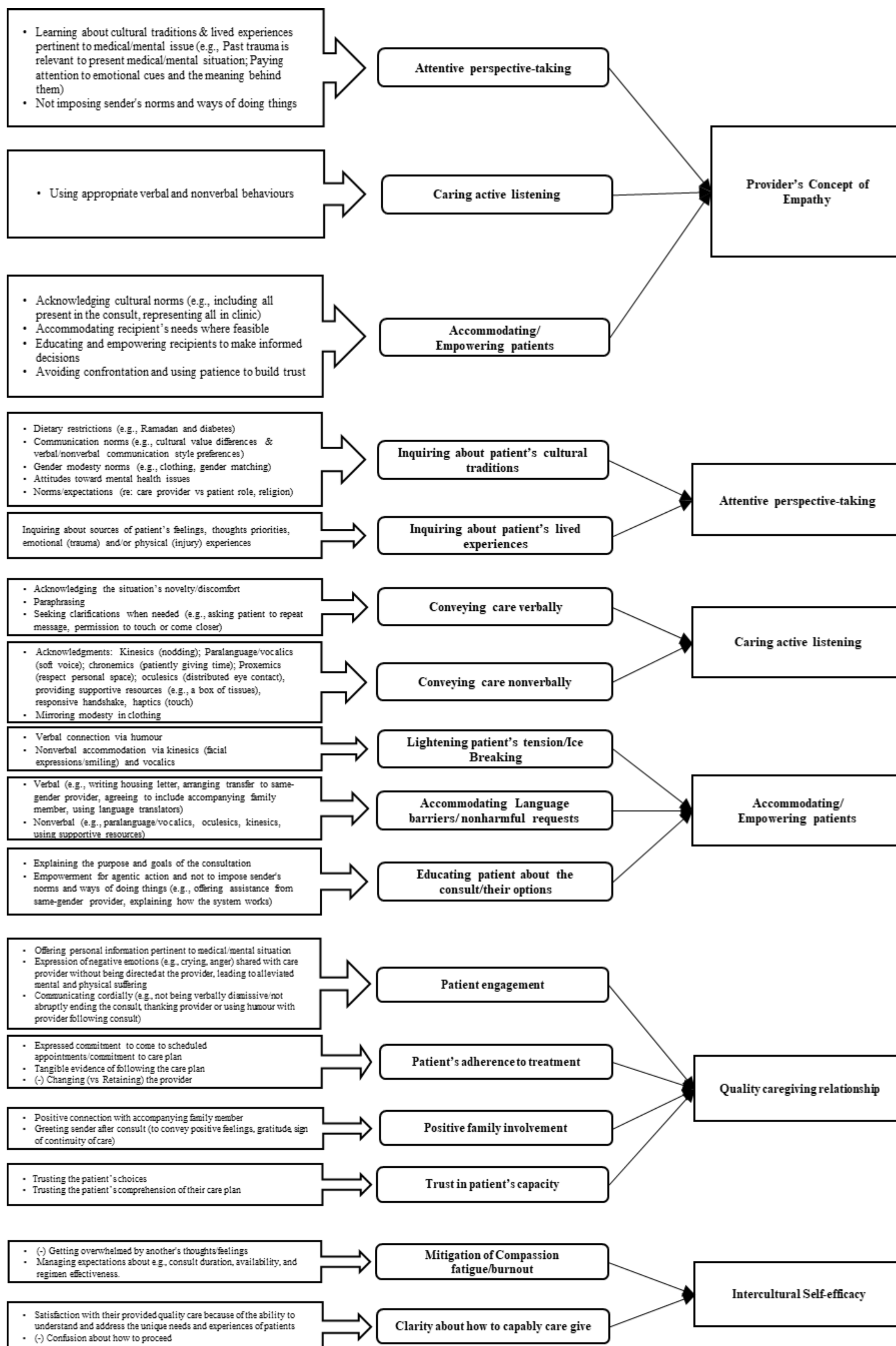
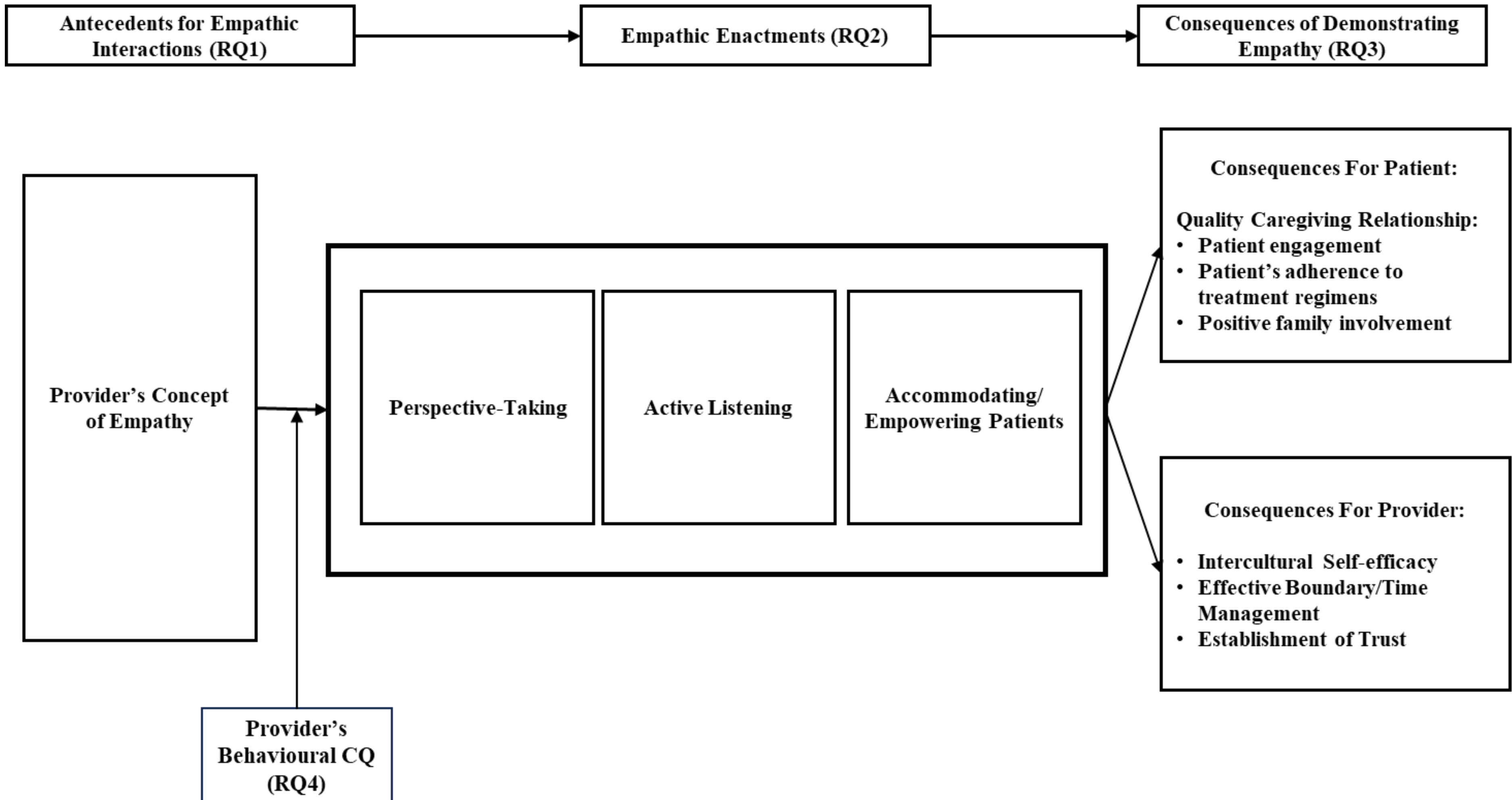


Figure 2. *Model of Caregiver Empathic communication*



Conclusion

The culmination of these three studies offers a comprehensive and insightful examination of empathic intercultural communication in healthcare. In this chapter, I provide summaries of the studies' findings and contributions, highlighting how the three studies complement and reinforce each other.

Study 1 addressed a significant gap in empathic communication literature. It explored the impact of empathy and nonverbal cues on intercultural communication from the recipient's perspective, constructing a theoretical model visually depicting the empathic communication process. This study developed a theoretical model that emphasized the role of nonverbal behaviours, cultural competency, and cultural expectations in shaping the experience of empathic interactions. It also categorized the outcomes of empathic communication into cognitive, affective, and behavioural dimensions, offering a more comprehensive and organized understanding of empathy. This work introduced empathy as a novel strategy for addressing communication challenges in intercultural contexts. However, it acknowledged the need for empirical validation in this regard.

Study 2 shifted the focus to Middle Eastern newcomers in Canada, emphasizing the under-researched area of empathic messaging from the recipient's perspective. It was an empirical paper which highlighted the impact of healthcare provider behaviours and systemic barriers on newcomers' perception of empathy. The study identified cognitive, affective, and behavioural responses to empathic or non-empathic communication and shed light on how recipients actively respond to healthcare communication challenges. The pivotal role of nonverbal behaviours in intercultural contexts was emphasized, along with systemic challenges and recipients' proactive interventions.

Study 3 delved into healthcare providers' conceptualization and enactment of empathic communication with Arab newcomer patients. It recognized the multifaceted nature of empathic communication and introduced strategies to demonstrate empathy effectively in intercultural settings. Positive outcomes included higher-quality caregiving relationships, improved patient adherence, and enhanced provider well-being. This study underlined the need for a comprehensive approach to addressing challenges faced in intercultural healthcare settings.

Collectively, these studies contribute to a deeper understanding of intercultural empathic communication, emphasizing the significance of nonverbal behaviours, cultural competency, and the need to address systemic barriers in healthcare contexts. They provide insights into both sender and recipient perspectives, highlighting the multifaceted nature of empathic communication in intercultural settings. Moreover, these studies do so not only by filling gaps in the literatures, but also by advancing our theoretical understanding in each of these fields of study.

Despite differences in the perspectives of providers and patients in the empirical studies and the lack of matched views, the studies underscore a significant communication gap that has implications for the effectiveness of healthcare interactions in intercultural contexts (illustrated in Table 1 below):

TABLE 1 HERE

System Influences: Patients view aspects of the healthcare system as significant barriers to receiving care, mainly because they did not receive any orientation about how to use the

system. At the same time, providers may be unaware of patients' systemic challenges. They may not realize the extent of patient assistance required to overcome these broader systemic issues.

On Outcomes: Providers and patients recognize the importance of compliance and engagement in empathic caregiving relationships, but they often have differing views on who is responsible for addressing systemic healthcare challenges. Providers may not factor these challenges into their attributions of patient engagement and compliance, while patients may not realize that providers consider their efficacy based solely on personal communication. Providers also are often unaware of the proactive interventions patients must independently undertake to navigate the healthcare system and negotiate for empathy.

On Comparing the Three Dimensions of Empathy: Both providers and patients value perspective-taking, active listening and empowerment, but there are differences in how these behaviours should be enacted, including nonverbal cues. Providers may lack cultural awareness and skills for these behaviours and may overlook patients' healthcare system challenges in their perspective-taking, which contributes to a gap in the perceived level of empathy.

In summary, these findings underscore the need for intercultural communication to consider both nonverbal behaviours and patients' cultural expectations. Closing this communication gap needs to be the responsibility of not only the healthcare providers, but also healthcare policymakers and cultural community associations. Empathic communication is crucial for effective healthcare delivery in intercultural contexts, both for the sake of the patient's health and for the providers' well-being. By recognizing and addressing these issues, healthcare providers and institutions can work towards reducing disparities and ensuring equitable care for individuals from diverse cultural backgrounds.

Table 1. Integrative Discussion

Pertinent Construct	**Provider**	**Patient**
System Influences		Healthcare System Consideration (e.g., orientation)
Outcomes	Compliance Engagement (inc. family) Trust in patient's capability Intercultural Self-efficacy	Compliance Engagement Proactive Intervention
Cognitive Empathy		Perspective-taken & Active Listening (e.g., culture-embedded helping)
Affective Empathy		Congruence felt (culture-embedded empowering words + NVBs – e.g., immediacy)
Behavioural Empathy	Perspective-taking Active listening Accommodating/Empowering	